SOCIAL SECURITY AND SUPPLEMENTAL SECURITY INCOME

BASIC PROGRAM CHARTS

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Social Security Administration
JULY 1976
OFFICE OF MANAGEMENT & ADMINISTRATION
OAAP PUB. NO. 020 (7-76)

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Social Security and Supplemental Security Income
Basic Program Charts

Part I—Social Security Basic Program Charts

Introduction

Retirement, Survivors, and Disability Insurance

Who Has Protection

How Much People Get

Health Insurance Program

Who Has Protection

What People Get

How Much People Pay

Social Security and Public Assistance

OUTLINE OF PRESENTATION ON SOCIAL SECURITY PROGRAM

Chart 1

Outline of Presentation on Social Security Program

This chart outlines the subjects covered in this presentation.

THE BASIC IDEA OF THE CASH BENEFITS PROGRAM

REPLACEMENT OF LOST EARNINGS

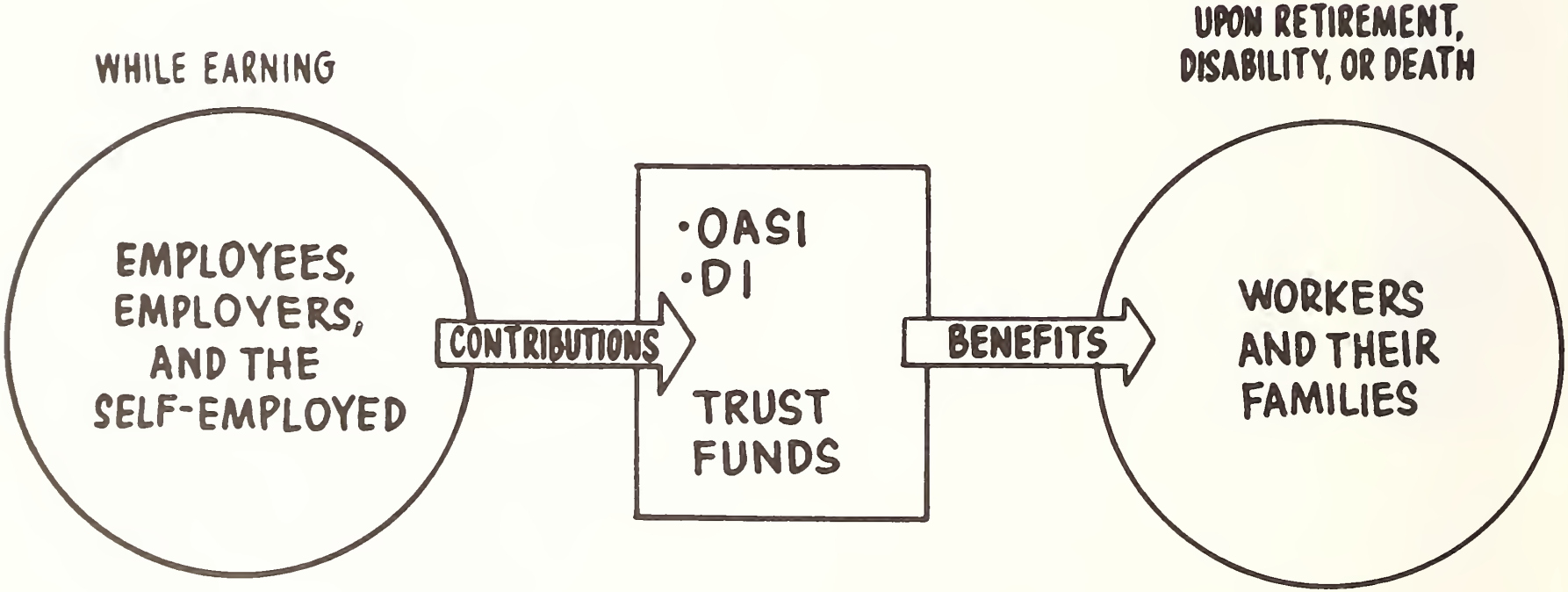


Chart 2

The Basic Idea of the Cash Benefits Program

The social security cash benefits program is a contributory social insurance system which is intended to protect a worker and his/her family against loss of earnings upon the retirement, severe disability, or death of the worker. The basic idea of the cash benefits program is that while they are working, employees pay social security contributions through an earmarked payroll tax which is matched by their employers (self-employed people contribute a percentage of their net income), and when earnings stop because of retirement (at age 62 or after), death, or disability, benefit payments are made, based on the worker's participation in covered employment, to replace part of the earnings that are lost. The contributions received, the benefits paid out, and the contingency reserves maintained are handled separately from Federal general revenue transactions in trust funds specially created for social security transactions.

9 OUT OF 10 JOBS ARE COVERED

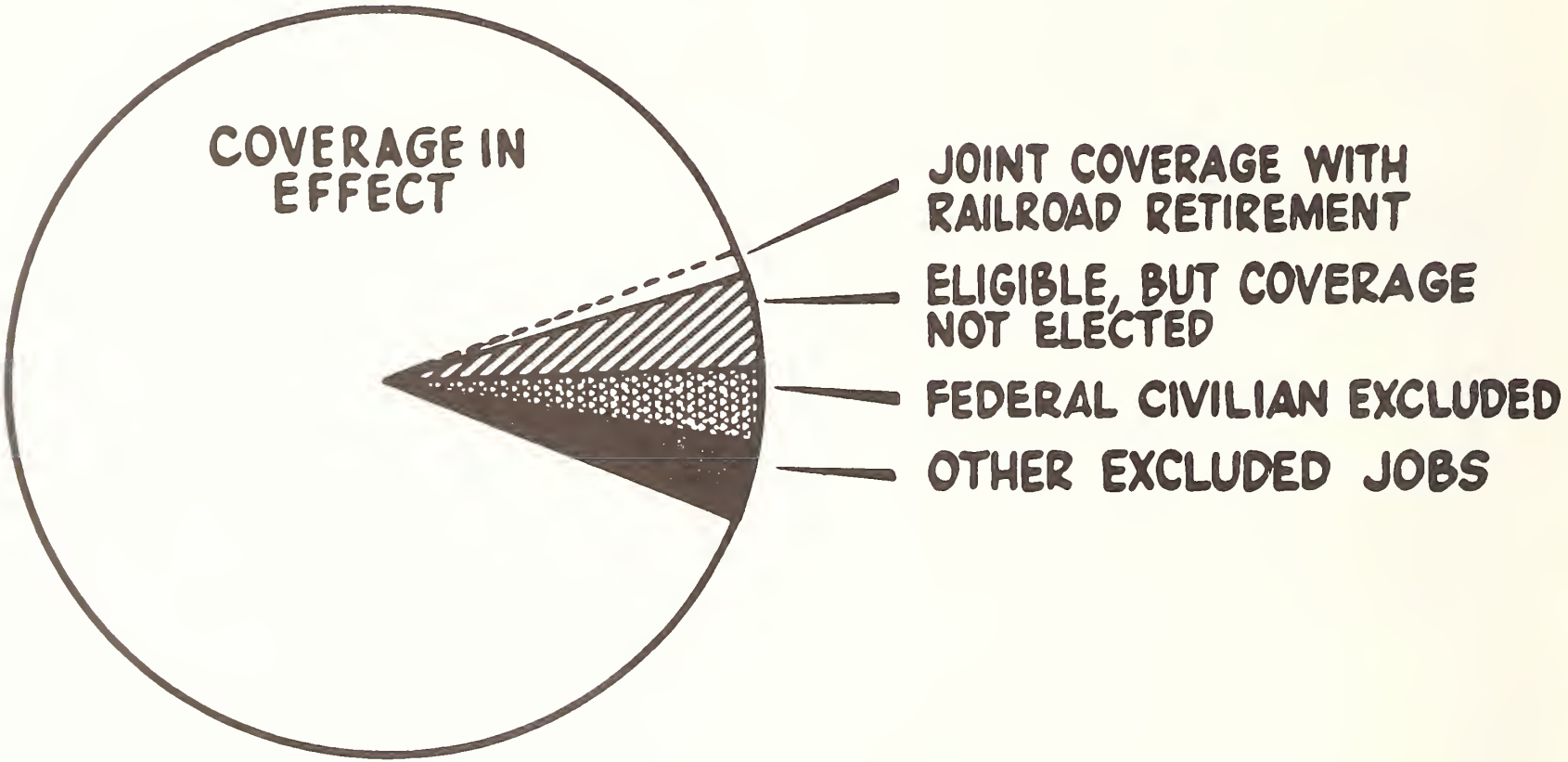


Chart 3
9 Out of 10 Jobs Are Covered

The first measure of the protection afforded by social security is the number of people now working in covered jobs.

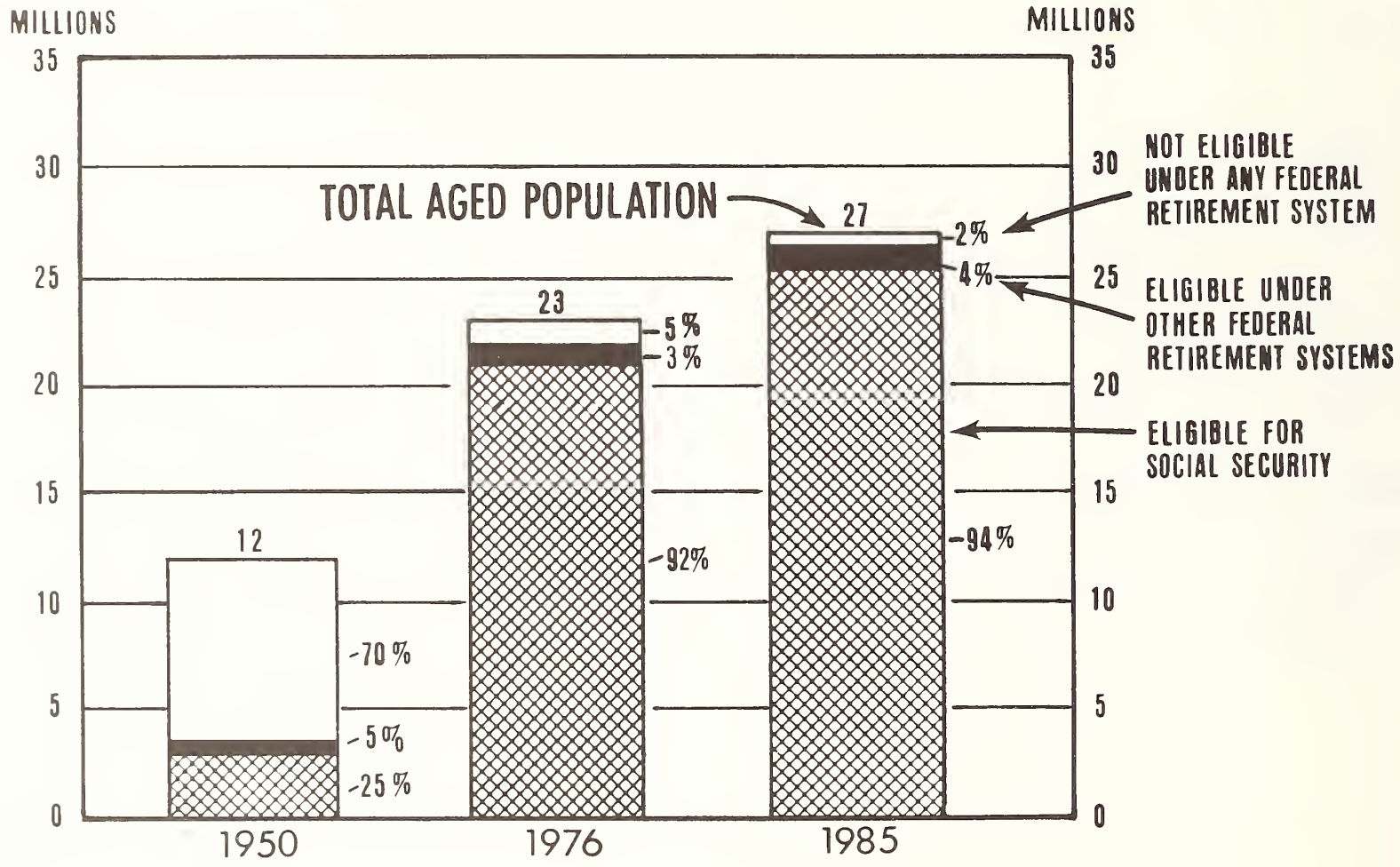
This chart shows paid employment in a single week, divided between the jobs covered under the social security program and those not covered. Railroad employment (550,000 jobs) is included as covered work because the railroad retirement program is coordinated with social security in such a way that railroad workers may be considered covered by both programs. In September 1975, about 90 percent of all jobs—about 78.0 million out of about 86.6 million—were covered under social security.

Of the 8.6 million jobs which are not covered, a large proportion are either jobs that are covered under other public retirement systems or jobs which represent irregular or part-time work.

For 4.0 million of the noncovered jobs, social security coverage is permitted by Federal law but coverage is not in effect. A very large proportion of these are state or local government jobs, almost all of which are under retirement systems. The remainder are either jobs for nonprofit organizations or represent self-employed persons with little or no net earnings who have not exercised their option to elect coverage based on a percentage of their gross earnings.

Of the 4.6 million jobs that are excluded by law from social security coverage, 2.5 million are in Federal employment that is covered by civil service retirement or one of the smaller Federal staff-retirement systems. Of the remaining 2.1 million jobs which are excluded from coverage, about four-fifths are jobs in which people do not earn enough or work long enough in a calendar quarter or a year to be covered, such as: self-employment when net earnings are less than $400 in a year (and gross income from self-employment is less than $600), and domestic work when payment is not as much as $50 in a quarter by any one employer. Farm workers are also not covered under social security unless the worker is paid at least $150 in cash wages by the employer during a calendar year or is employed by the employer on 20 or more days during the year and paid on a time basis—per hour, day, or other time period. Some persons who are not primarily in the labor force—for example, retired people, students, or housewives—may be working in some of these noncovered jobs. Some regular workers are in these noncovered jobs: some farm and household workers who work at low wages or for short periods for each employer and some policemen under state and local government retirement systems.

PROTECTION FOR OLDER PEOPLE*



*AGE 65 AND OVER

Chart 4
Protection for Older People

This chart shows how the effectiveness of the social security program in providing income for older people has increased since 1950 and how it will continue to increase in the coming years.

In 1950, fewer than 6 out of 10 people in paid jobs were covered under social security, and only 25 percent of the people age 65 and over were eligible for social security benefits. Since then, protection has been extended to millions of workers who previously were not covered—the self-employed, farm and household workers, members of the Armed Forces, and most employees of state and local governments and nonprofit organizations—so that today, 9 out of 10 jobs are covered under the program, and 92 percent of the people aged 65 and over are eligible for cash benefits.

Under the social security program, a worker must be fully insured to qualify for retirement benefits for self and family. A worker who reaches age 62 in 1975 or later is fully insured if he/she has at least one quarter of coverage (acquired at any time after 1936) for each calendar year elapsing after 1950 (or, if later, after the year in which he/she attained age 21) and up to the year in which the person attains age 62, dies, or becomes disabled. (Generally, an employee earns a quarter of coverage for each calendar quarter in which $50 is paid; the self-employed person earns four quarters of coverage for a calendar year in which the person has net earnings from self-employment of at least $400.) The maximum requirement is 40 quarters, or 10 years of covered work.

As of January 1, 1976, 92 percent—about 21 million—of the about 23 million people aged 65 and over either were getting monthly cash social security beneifts, or would have been getting them if they or their spouses were not working. (Included in the 21 million aged people eligible for benefits are about 224,000 noninsured people aged 72 and over who were eligible for special payments.)

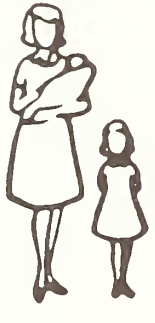
Ninety-five percent of the people aged 65 and over are eligible for monthly benefits under social security or other Federal retirement systems, such as the railroad retirement program and the civil service retirement program.

Of the about 1.8 million people reaching age 65 in 1976, about 95 percent are eligible for monthly benefits under social security. Of the people reaching age 65 in 1976, about 98 percent are eligible for benefits under some Federal retirement system.

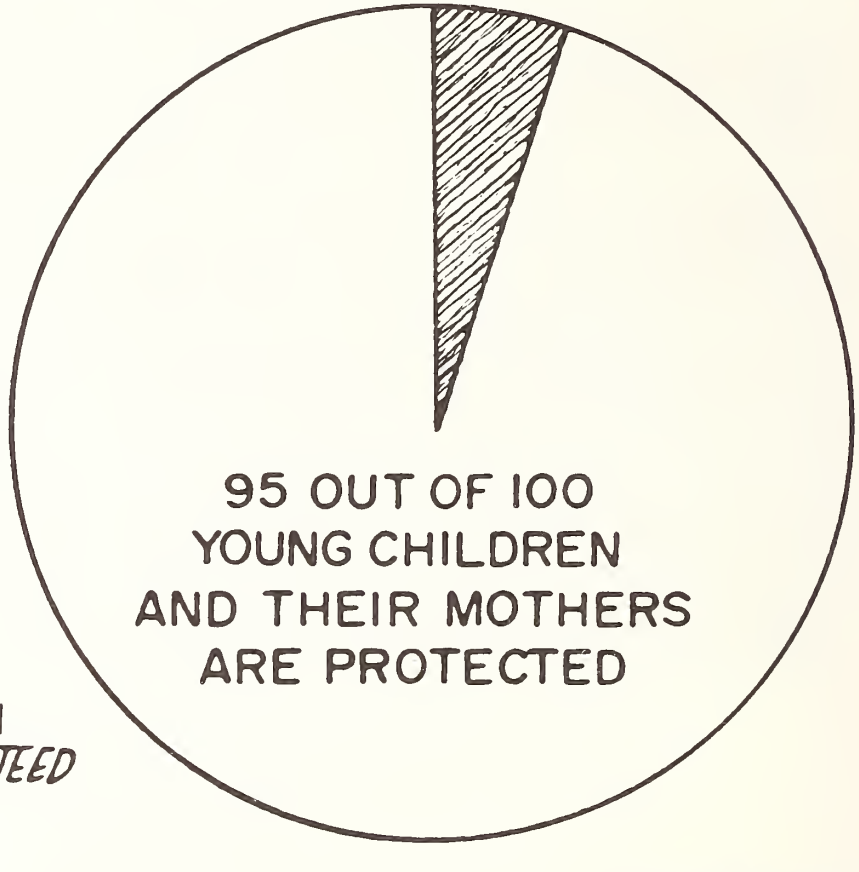
The proportion of the aged who will have social security income protection will increase over the years because more people will have had the opportunity to work in covered employment long enough to be insured. By the year 1985, about 94 percent of the aged population will be eligible for social security cash benefits, and this percent will rise to about 96 to 98 percent by the year 2000. By then, just about all will be covered by some Federal retirement system.

SURVIVORS PROTECTION

124 MILLION PEOPLE ARE INSURED FOR SURVIVORS BENEFITS



$113,200



INSURANCE PROTECTION FOR A WORKER WITH A WIFE AND TWO CHILDREN WHERE THE WORKER'S AVERAGE EARNINGS ARE $600, HAS A PRESENT VALUE OF $113,200 AND IS GUARANTEED INFLATION PROOF

January 1, 1976

Chart 5
Survivors Protection

This chart shows the proportion of children and their mothers who are protected under the social security program in the event of the death of the father. As of January 1, 1976, 124 million people were insured for survivors benefits under the social security program.

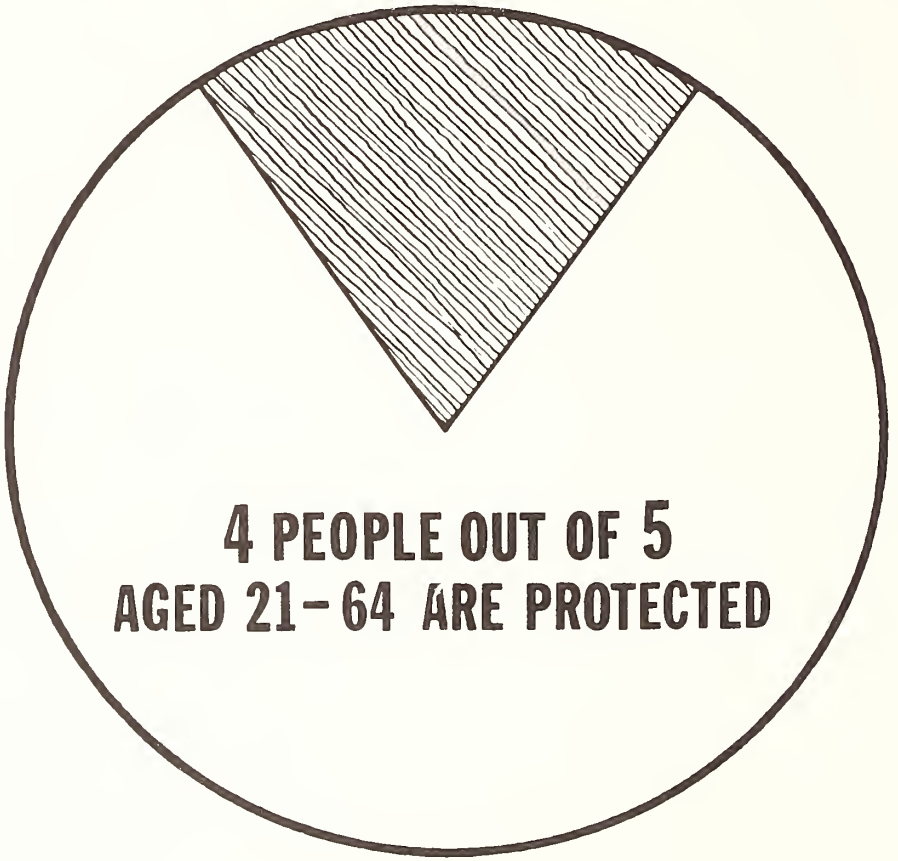
Social security survivors' benefits are payable to the children and to the young widow or widower of the worker if the worker was either fully insured or currently insured. A worker is currently insured if he or she had at least 6 quarters of coverage during the 13-quarter period ending with the calendar quarter in which he or she died.

Ninety-five out of every 100 children under age 18 and their mothers have survivorship protection—that is, they would be able to draw monthly cash benefits if the father were to die. In addition to the protection for the young family, survivors' insurance benefits are payable to aged widows, aged dependent widowers, aged dependent parents, children age 18-22 who are full-time students, and children aged 18 and over who were disabled before age 22.

The value of survivors insurance protection for a family with young children depends largely on the number and age of the children and on the earnings of the worker. For example, in the case of a young worker with average monthly earnings of $600 who dies in 1976 leaving a wife aged 32 and two small children aged 3 and 5, the present value of the social security benefits that will be paid to that family over the years (assuming that the children will attend school until they reach age 22) is $113,200 and is guaranteed inflation proof.

DISABILITY PROTECTION

86 MILLION PEOPLE ARE INSURED FOR DISABILITY BENEFITS



January 1, 1976

Chart 6
Disability Protection

This chart shows the proportion of adults who are protected under the social security program (either as insured workers or as dependents of insured workers) against loss of earnings due to long-term disability.

To be insured for social security disability protection, a worker aged 31 or older must be fully insured and, unless blind, must also have at least 20 quarters of social security coverage (about 5 years of covered work) during the period of 40 calendar quarters (10 years) ending with the quarter in which he/she becomes disabled. An alternative insured-status requirement is available to workers disabled while young. A worker disabled before age 31 must ordinarily have quarters of coverage in half the calendar quarters elapsing after reaching age 21, and up to and including the calendar quarter in which the worker becomes disabled. However, if a worker becomes disabled before age 21 or before 12 calendar quarters have elapsed after reaching age 21 (in general, at any age before age 24), the worker is insured if he/she has at least 6 quarters of coverage within the 12-calendar quarter period ending with the quarter in which he/she becomes disabled.

Disability protection includes—in addition to the payment of benefits—the establishment of a period of disability (disability freeze). A disability freeze protects the worker and family against loss or reduction in the amount of retirement, disability, or survivors benefits by providing that the period of disability will not be counted in determining insured status or benefit amount.

Benefits may be paid to children of the disabled worker and to his wife if she is age 62 or if she has an entitled child in her care. Additionally, protection is provided in some cases based on the disability of the dependent of an insured worker. People who are disabled before age 22 are protected in the event of the death, disability, or retirement of an insured parent. Disabled widows and widowers may receive reduced benefits as early as age 50.

As of January 1, 1976, a total of 86 million workers at all ages under 65—55 million men and 31 million women—are estimated to have been insured against the loss of their earnings in the event of long-term disability. About 9 out of 10 men, and 2 out of 5 women aged 21-64, are insured. Most men who are not insured either have only very recently entered the labor market or have worked primarily in non-covered jobs.

About 4 out of 5 people aged 21-64 have protection in the event of the breadwinner's long-term disability (either as insured workers or as dependents of insured workers). These include about 7 out of 10 of all women in this age group.

The present value of the survivors and disability insurance protection for a man who becomes disabled at age 35, with a wife aged 32 and two children aged 3 and 5, who has averaged monthly earnings of $600 (assuming the man should die after being disabled for 5 years) is about $115,500 and is guaranteed inflation proof.

32.1 Million People Get Benefits Each Month

(1 Out Of 7 Americans)

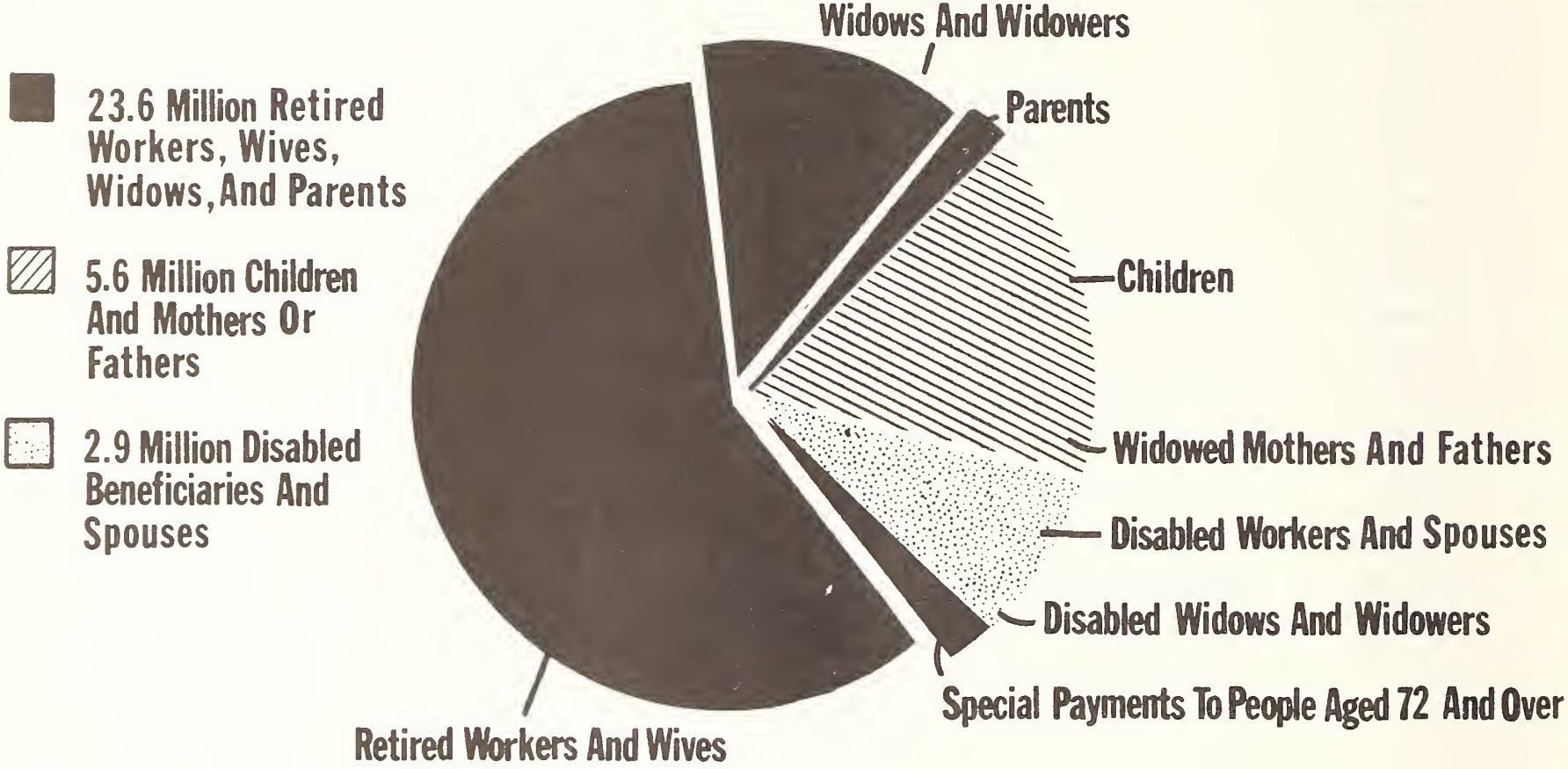


Chart 7

32.1 Million People Get Benefits Each Month

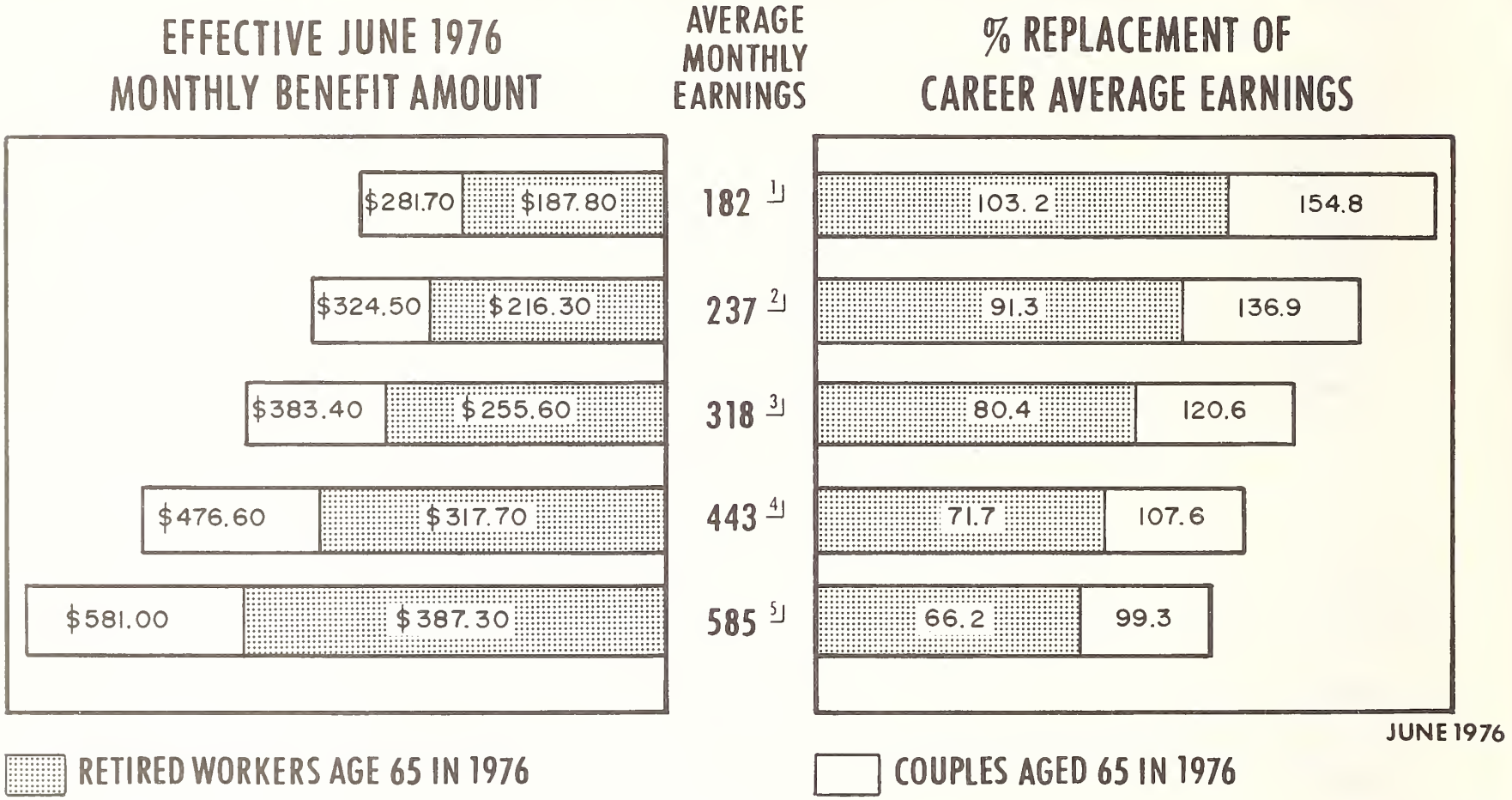
Nearly 32.1 million people (more than 1 person in every 7) were getting monthly social security benefit checks as of December 31, 1975.

Cash benefits for retired workers and their wives (or husbands) and for aged survivors (except widows and widowers) are payable at age 62; widows and widowers can start getting their benefits at age 60, or at age 50 if disabled. 60.6 percent (19.5 million) of these 32.1 million beneficiaries are retired workers and their wives (or husbands).

About 15.5 percent (5 million) of all beneficiaries are children of retired, deceased, or disabled workers. About 1.8 percent (582,000) are young widowed mothers or fathers with children in their care. About 0.7 percent (224,000) are receiving special age-72 payments. Over 12 percent (about 3.9 million) are widows and widowers (including about 0.1 million disabled widows and widowers). Less than one-tenth of 1 percent (21,000) are dependent parents of deceased insured workers. As of the end of December 1975, 20.6 million beneficiaries aged 65 and over were getting benefits.

Benefits are also paid to insured workers who are so severely disabled that they cannot engage in substantial gainful work and to their dependents. Disabled beneficiaries under age 65 and spouses of disabled workers (over 2.9 million) make up 9.2 percent of the beneficiary rolls.

BENEFIT AMOUNTS ARE RELATED TO AVERAGE MONTHLY EARNINGS



1 EARNINGS EQUAL TO $3,438 IN 1975 WITH INCREASES PARALLELING INCREASES IN AVERAGE 1 ST. QTR WAGES 1951-75

2 " " " THE FEDERAL MINIMUM WAGE 1951 - 1975

3 " " " AVERAGE TAXABLE WAGES UNDER SOCIAL SECURITY 1951 - 1975

4 " " " MALE MEDIAN EARNINGS UNDER SOCIAL SECURITY 1951 - 1975

5 " " " THE CONTRIBUTION AND BENEFIT BASE UNDER SOCIAL SECURITY 1951 - 1975

Chart 8

Benefit Amounts Are Related to Average Monthly Earnings

The benefit amounts shown in the table are payable for June 1976.

The amount of the monthly cash benefit that a worker gets is determined by his/her average monthly earnings in covered work over a specified number of years.[1] The number of years generally used is equal to five less than the number of years elapsing after 1950, or after age 21, if later, and up to the year in which the worker reaches age 62,[2] becomes disabled; or dies. The provision allowing up to 5 years in which earnings were lowest to be dropped from the computation of average monthly earnings provides some protection against the lowering of average monthly earnings and, consequently, benefit amounts because of periods of sickness or unemployment, or because of employment in jobs that were not covered by the program.

The earnings used in computing benefits include only earnings up to a specified amount for any year. Since it has not been considered appropriate to cover the full earnings of highly-paid people and to pay correspondingly high benefits, there has always been an upper limit on the amount of annual earnings on which contributions are paid and which are creditable for benefit purposes (the so-called contribution and benefit base). Beginning with $3,000 in 1937, the base has been increased in several steps over the years. For 1976, the base is $15,300 and the law provides for future automatic adjustments of the base to increases in average covered wages.

While both benefits and contributions are related to earnings, they are related somewhat differently. The contribution rate is a uniform rate applied to each dollar of covered earnings in a year. The benefit amounts, on the other hand, are weighted in favor of those with low earnings in recognition of the fact that those with low earnings have less margin for reduction in their income. Thus, the worker with low covered earnings gets a lower benefit than the worker with higher earnings, but the low benefit replaces a larger percentage of the earnings on which it is based than does the higher benefit.

There are, of course, various ways in which percentage replacements could be computed. The percentages shown in the chart describe the relationship between the worker's career average earnings and his/her benefit. Since in most cases earnings rise over one's working career, the percentages would be somewhat lower than those shown if they described the relationship between earnings just before retirement and benefits. For example, the worker with earnings of $3,438 in 1975 gets a benefit which replaces 65.5 percent of the 1975 earnings compared to 103.2 percent of the career average earnings.

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[1]The special minimum benefit provides an alternative benefit computation for people who have worked at low earnings for many years under social security. The benefit amount is equal to $9 for each year of coverage that a person has beyond 10 and up to a maximum of 30. A person who had 25 years of coverage, for example, can get a special minimum of $135 at age 65, a person who had 26 years, $144, and so forth, up to $180 for a person with 30 or more years of coverage. A year of coverage is, in general, any year in which a person has earned at least 25 percent of the maximum social security earnings creditable in a year. This special benefit will not be increased under the provisions for automatic adjustment of benefits to reflect increases in prices.

[2]Under present law, men who reached age 62 in or before 1972 have their earnings averaged up to age 65, men who reached age 62 in 1973 have their earnings averaged up to age 64, and men who reached age 62 in 1974 have their earnings averaged up to age 63. Men who reach age 62 in 1975 or later will have their earnings averaged up to age 62, as is now the case for women.

AUTOMATIC ADJUSTMENT OF BENEFITS TO PRICES (IN ABSENCE OF CONGRESSIONAL ACTION TO INCREASE BENEFITS)

1. **WHEN THE CPI INCREASES AT LEAST 3 PERCENT**

2. **INCREASES NO MORE OFTEN THAN ONCE A YEAR**

Chart 9

Automatic Adjustment of Benefits to Prices

The law provides for automatically increasing benefits to reflect increases in prices, so that social security beneficiaries have the assurance of knowing that the real value of benefits will not decline.

Benefits can be increased automatically each June whenever the cost of living rises 3 percent or more between specified base periods. However, an automatic benefit increase will not go into effect if in the year preceding the June for which it would otherwise become effective a general benefit increase has become effective or has been enacted.

Each year, the Secretary of Health, Education, and Welfare will compare the monthly average of the Consumer Price Index for the first calendar quarter with the monthly average of the Index for the most recent first calendar quarter which was used to compute an automatic benefit increase or, if later, the calendar quarter in which a legislated benefit increase became effective. If the rise in the Consumer Price Index over the measuring period is 3 or more percent, the Secretary is required to promulgate (not later than May 15) the benefit increase, effective for the following June.

AUTOMATIC ADJUSTUSTMENT OF CONTRIBUTION AND BENEFIT BASE:

1. **BASE INCREASED BY PERCENTAGE INCREASE IN AVERAGE WAGES, ROUNDED TO NEAREST $300**

2. **BASE CAN BE INCREASED AUTOMATICALLY ONLY FOR A YEAR FOLLOWING AN AUTOMATIC BENEFIT INCREASE**

Chart 10

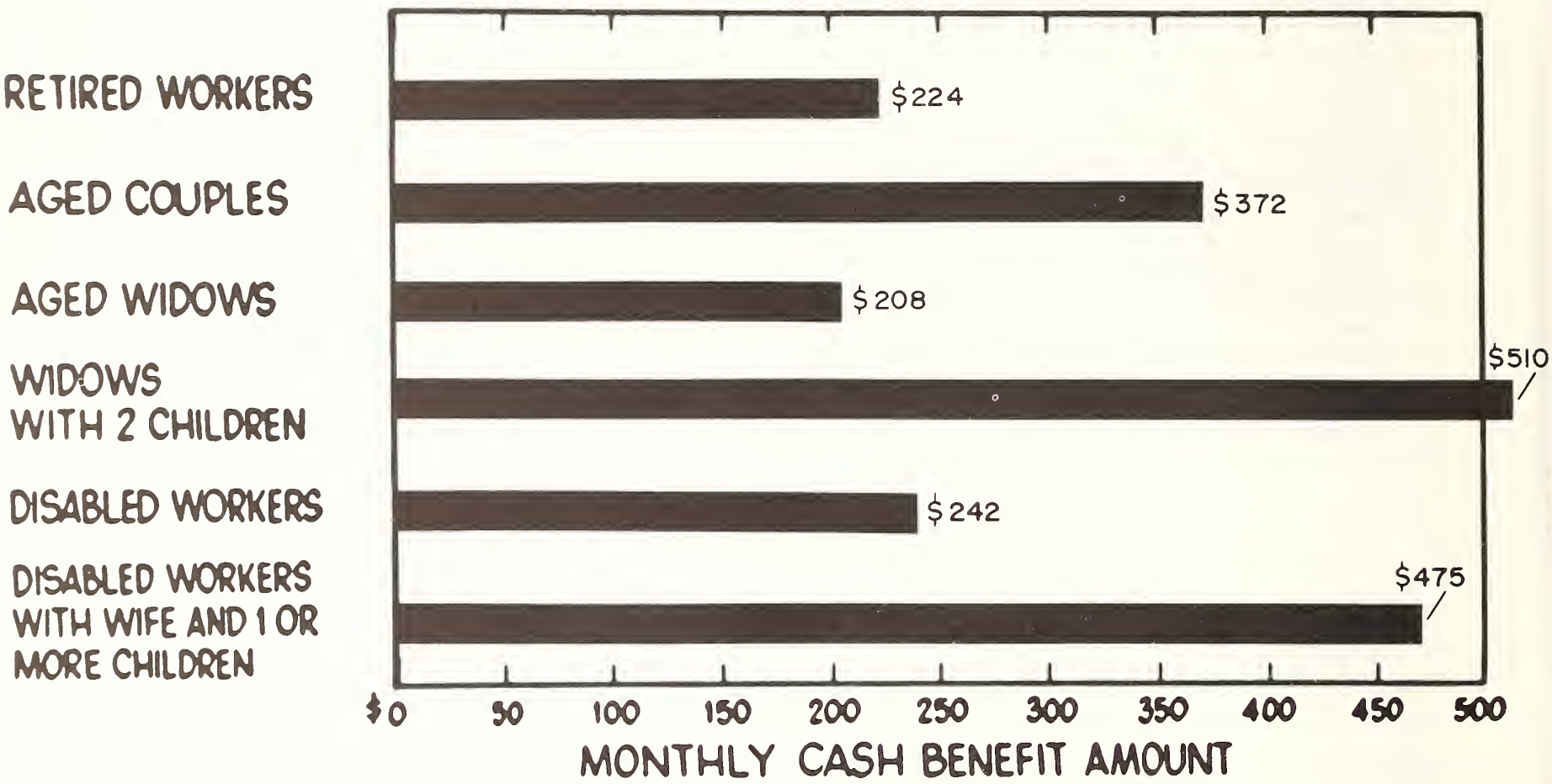
Automatic Adjustment of Contribution and Benefit Base

The law provides for automatic adjustment of the contribution and benefit base—the maximum amount of a worker's annual earnings on which social security contributions are paid and which is counted for social security benefit purposes. The base is automatically increased in proportion to the increase in the level of average covered wages in the first calendar quarter of the year in which the computation is made over the level of average covered wages in the first calendar quarter of the latest of the most recent year in which an increase in the contribution and benefit base was enacted or the most recent year in which a determination was made to automatically adjust the contribution and benefit base. An automatic increase in the contribution and benefit base can go into effect only for the year following a year in which an automatic benefit increase becomes effective. The base was increased to $15,300 for 1976 under the automatic provisions.

Increases in the contribution and benefit base strengthen the effectiveness of the program because more workers than under prior law will be able to get benefits related to their full earnings. The contribution and benefit base is a major factor in determining the level of social security protection for workers with above-average earnings. If the base were not increased, more and more workers, as time goes on, would have earnings above the base amount, and the benefits of these workers would be related to a smaller and smaller part of their earnings. Eventually, almost everyone would be earning at or above the maximum creditable amount and would get a flat benefit amount, unrelated to actual earnings.

While the $3,000 base in 1938 provided the highest level of coverage since the beginning of the program—97 percent of all workers had their full earnings covered—the $15,300 base will cover the full earnings of about 85 percent of all workers in 1976. This compares quite favorably with the level established during the 1950's when some 75 percent of all workers had all of their earnings covered.

AVERAGE CASH BENEFITS



JUNE 1976

Chart 11
Average Cash Benefits

This chart shows average monthly benefits for some selected family groups.

The benefits paid to disabled workers do not ordinarily include reduced benefits, and a higher percentage of disabled workers than retired workers have their benefits computed on more recent, and therefore higher, average earnings. These facts explain, at least in part, why the average benefit for disabled workers is higher than the average for retired workers—$242 compared with $224 for June 1976.

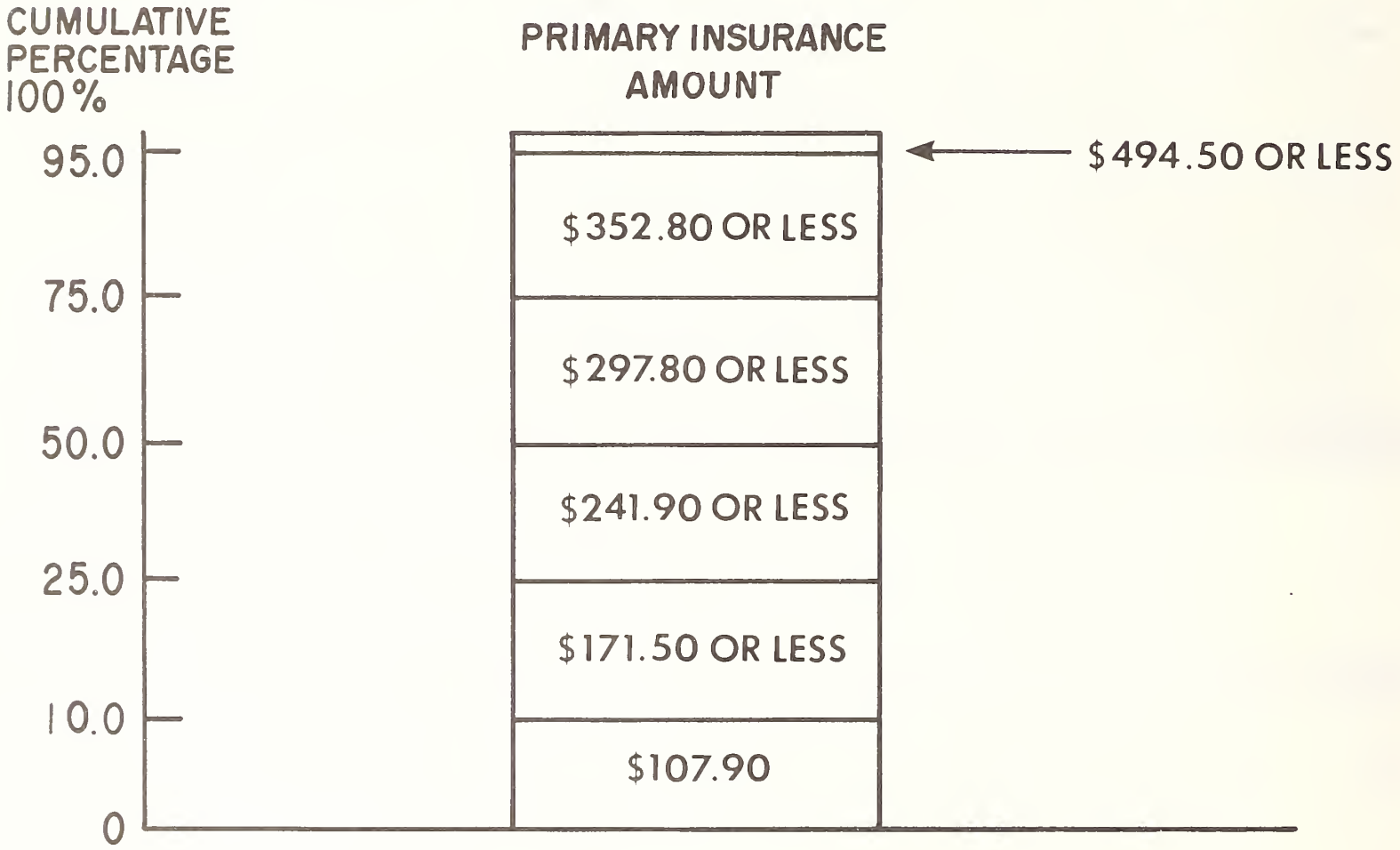
A wife's benefit beginning at or after age 65 is equal to one-half of the amount her husband would get if he retired at age 65. The average benefit for a worker and his wife is $372.

The amount of a widow's benefit depends on her age at the time she starts getting benefits (payable as early as age 60) and whether her husband got reduced retirement benefits. An aged widow's benefit beginning at or after age 65 is 100 percent of the benefit her husband was getting or would have gotten if he retired at age 65. The average benefit for aged widows is $208.

Several factors affect the amount of benefits for family groups consisting of several people. A child's benefit is 50 percent of the worker's unreduced benefit if the worker is alive, and 75 percent if the worker is dead. Also, there is a limit on the monthly family benefits payable on the basis of an insured worker's earnings record. The maximum family benefits range in amount from 150 percent of the minimum unreduced benefit for a worker to 175 percent of the maximum unreduced benefit under the law. Under the automatic provisions in the law, the family maximums will be increased by the same percentage as benefits are increased.

The benefit for a dependent parent of a deceased worker is 82 1/2 percent of the worker's benefit if there is one parent, and 75 percent each if there are two parents.

PERCENTAGE DISTRIBUTION OF OLD-AGE INSURANCE BENEFICIARIES* IN CURRENT-PAYMENT STATUS



* DOES NOT INCLUDE DUAL - ENTITLED AND TRANSITIONAL INSURED BENEFICIARIES

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Chart 12

Percentage Distribution of Old-Age Insurance Beneficiaries in Current-Payment Status

The preceding chart showed the average benefits payable to selected family groups. This chart shows the estimated percentage distribution, by primary insurance amount (PIA), of all retired workers (excluding: (1) persons dually entitled to an old-age benefit and a supplemental wife's or widow's benefit, and (2) transitional insured persons aged 72 and over) on the rolls at the beginning of June 1976.

There is a considerable percentage of retired workers (about 10 percent) receiving benefits based on the minimum PIA of $107.90. About 50 percent are receiving benefits based on a PIA of more than $241.90.

The maximum possible PIA for a worker retiring at age 65 in June 1976 is $387.30. The highest possible PIA for any retired worker payable for June 1976 is $494.50. These figures will increase in the future both as a result of the higher earnings creditable as the contribution and benefit base increases, and as a result of automatic increases in benefits to reflect increases in the cost of living.

THE AMOUNT A BENEFICIARY CAN EARN . . . *and still get benefits*

ANNUAL EXEMPT AMOUNT*		$2,760
$1 FOR $2 REDUCTION	above	$2,760
MONTHLY EXEMPT AMOUNT*		$ 230

* FIGURES ARE FOR 1976; WILL BE AUTOMATICALLY INCREASED IN FUTURE AS EARNINGS LEVELS RISE.

Chart 13

The Amount a Beneficiary Can Earn and Still Get Benefits

A basic purpose of the social security program is to provide cash benefits to partially replace earnings that are lost when a worker becomes disabled, dies, or retires in old age. Retirement benefits are not payable simply because a person has reached a given age; the law provides that benefits can be withheld if a person has substantial earnings from work, and the amount withheld depends on the amount of those earnings. The provision for withholding benefits in such cases, generally referred to as the retirement test, is applicable to dependents and survivor beneficiaries, as well as to retired workers. The elements of the present retirement test are as follows:

1. *An annual exempt amount of earnings:* Annual earnings up to $2,760 are exempt from the test; a beneficiary who earns no more than $2,760 in 1976 can get full benefits for the year.

2. *A reduction in benefits for earnings above the exempt amount:* A beneficiary who earns more than $2,760 in 1976 has $1 in benefits withheld for each $2 of earnings above that amount.

3. *A monthly exemption:* Regardless of annual earnings in 1976, a beneficiary who neither earns more than $230 nor renders substantial services in self-employment in a month, gets full benefits for that month. A monthly exemption is necessary in order to enable the program to meet its objective of providing benefits to people immediately upon retirement, and during other periods after they have qualified for benefits when they do not have income from work.

4. *Automatic increases in exempt amounts:* The annual exempt amount and the monthly exemption are automatically increased to keep pace with increases in general earnings levels.

5. *An exemption on account of age:* Benefits are payable to a beneficiary for all months beginning with the month he reaches age 72, regardless of the amount of his earnings. This provision was included because, otherwise, people who continue working to a very advanced age would never get benefits, even though they had paid contributions longer than most other people.

6. *Nonwork income not counted:* The retirement test applies only to income from work; benefits are not withheld because of income from nonwork sources since this might decrease the incentive for people to supplement their social security benefits through personal savings, private pensions, and the like.

Under these provisions, people can have fairly substantial earnings and still get some of their benefits. For example, a male worker eligible for a monthly benefit amount of $200—$2,400 for the year—could earn $5,000 a year and still get $1,280 in social security benefits for the year. If the man is married, he and his wife would be eligible to receive monthly benefits of $300—$3,600 for the year; he could earn $5,000 in 1976 and the couple would still get $2,480 in benefits for 1976.

THE BASIC IDEA OF THE MEDICARE PROGRAM

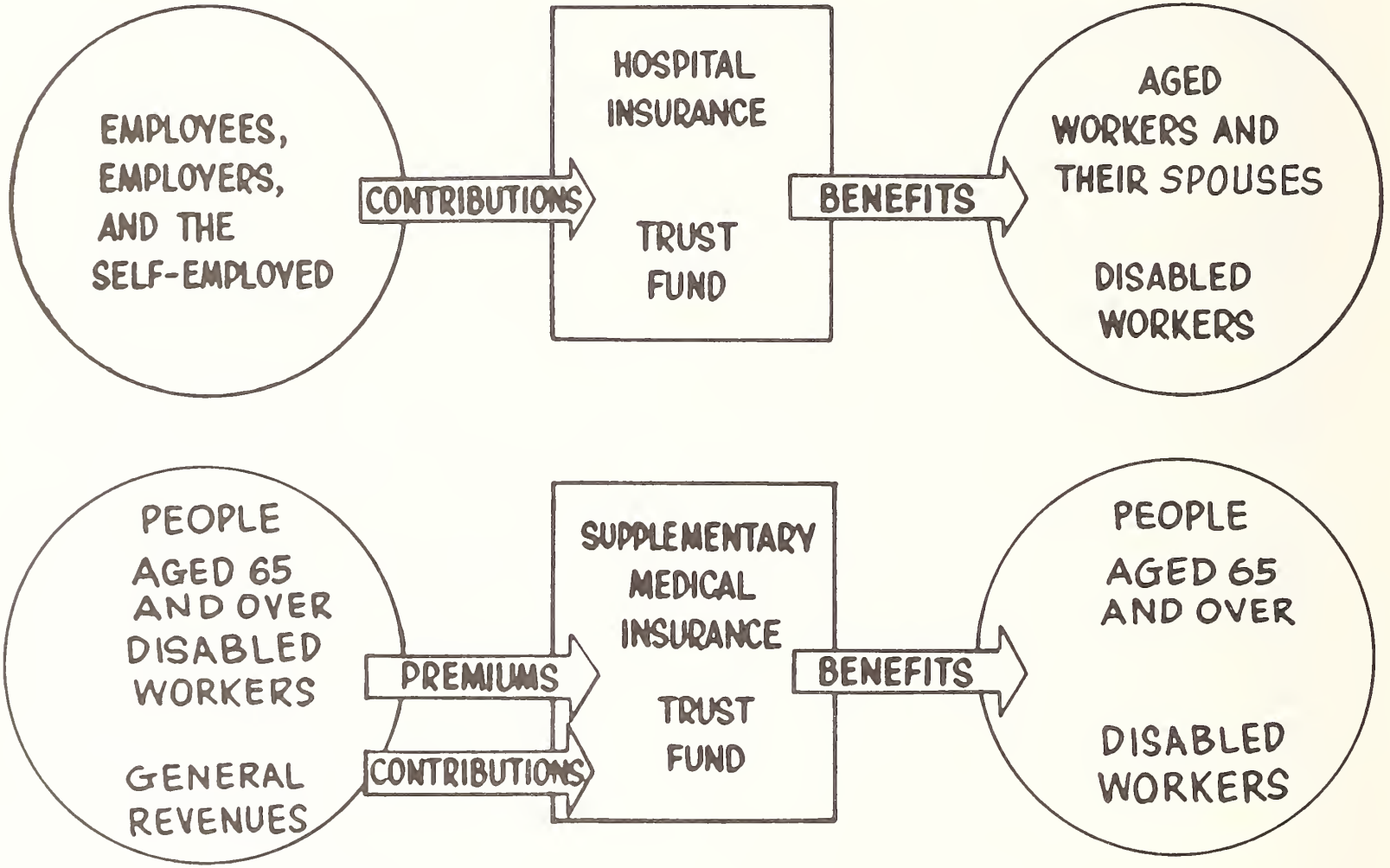


Chart 14

The Basic Idea of the Medicare Program

Hospital Insurance

Medicare hospital insurance, like the cash benefits program, is financed on a self-supporting basis through contributions on current earnings paid by employees, employers, and self-employed persons. The hospital insurance trust fund makes payments for covered hospital services, as well as for post-hospital skilled nursing facility and home health services. Persons eligible for these benefits include everyone aged 65 or older who is entitled to monthly social security or railroad retirement benefits; almost all other persons who became 65 before 1968 (under a special temporary provision); uninsured persons age 65 or over who purchase this coverage voluntarily; disabled persons under age 65 who have been entitled to benefits based on disability for 2 years; and workers and their dependents who need dialysis or transplantation due to chronic renal disease. (The latter two groups became eligible beginning July 1, 1973.)

Supplementary Medical Insurance

The supplementary medical insurance plan, covering the costs of physicians' services and related medical care for all persons entitled to hospital insurance and most other persons over 65, operates somewhat differently. The supplementary medical insurance program is financed through a trust fund into which go premiums from those eligible persons who voluntarily enroll in the program and Federal general revenue contributions sufficient to meet the full cost of the program.

MEDICARE ELIGIBILITY

◉ HOSPITAL INSURANCE AND SUPPLEMENTARY MEDICAL INSURANCE

PERSONS AGED 65 AND OVER

- ALL PERSONS ELIGIBLE FOR MONTHLY CASH BENEFITS
- UNINSURED PERSONS "BLANKETED IN" IN EARLY YEARS OF PROGRAM
- OTHER UNINSURED PERSONS WHO PAY FULL COST FOR HI PROTECTION

  ($45 Effective 7/1/76)

PERSONS UNDER AGE 65

- ALL PERSONS RECEIVING MONTHLY CASH DISABILITY BENEFITS FOR 24 CONSECUTIVE MONTHS
- CERTAIN CHRONIC RENAL DISEASE PATIENTS WHO ARE FULLY OR CURRENTLY INSURED OR ARE RECEIVING MONTHLY SOCIAL SECURITY BENEFITS (OR WHO ARE DEPENDENTS OF SUCH PERSONS)

Chart 15

Medicare Eligibility

Medicare protection (both hospital insurance and supplementary medical insurance) is available to virtually everyone aged 65 and over and to certain groups of people under age 65. All persons who are eligible for monthly cash benefits under the social security or railroad retirement programs are eligible for hospital insurance at age 65.

In addition, certain uninsured persons who attained age 65 prior to 1968 or who attained age 65 after 1967 and had gradually increasing amounts of covered work are eligible for hospital insurance protection under a special temporary provision of the Medicare law. (This provision "washed out" for men in 1975 and for women in 1974 when the number of quarters of coverage required for eligibility became the same for both hospital insurance and cash benefits.) Those uninsured persons aged 65 and over, who are not otherwise eligible for hospital insurance, may enroll, on a voluntary basis, for such coverage. They are required to pay the full cost of their hospital insurance protection—$45 per month beginning July 1, 1976—and must also enroll for supplementary medical insurance.

About 2.3 million social security beneficiaries under age 65 who have been receiving.benefits on the basis of a disability for 24 or more consecutive months are entitled to Medicare protection. Those covered include disabled workers; disabled widows and disabled dependent widowers between the ages of 50 and 65; women, aged 50 or older, entitled to mother's benefits who, for 24 months prior to the first month they would be entitled to Medicare protection, met all requirements for disabled beneficiaries except for filing of disability claim; people aged 18 and over who receive social security benefits because they became disabled before reaching age 22; and disabled qualified railroad retirement annuitants. Medicare protection is also available to individuals under age 65 who are currently or fully insured or entitled to monthly social security or railroad retirement benefits, and to the spouses and dependent children of such individuals who require dialysis or transplantation for chronic renal disease.

Both the aged and disabled, except for residents of Puerto Rico and foreign countries, are automatically enrolled for supplementary medical insurance as they become entitled to hospital insurance. Persons eligible for automatic enrollment are given an opportunity to decline this coverage. All enrollees are responsible for the supplementary medical insurance premium ($7.20 per month as of July 1, 1976).

HOSPITAL INSURANCE

Covered Services:

INPATIENT HOSPITAL CARE

- 90 DAYS PER BENEFIT PERIOD
- 60 DAY LIFETIME RESERVE

DEDUCTIBLE — $104

COST SHARING — PATIENT PAYS $26 PER DAY FOR 61ST THRU 90TH DAY

— PATIENT PAYS $52 PER DAY FOR EACH OF LIFETIME RESERVE DAYS USED

POST-HOSPITAL EXTENDED CARE

- 100 DAYS PER BENEFIT PERIOD

COST SHARING — PATIENT PAYS $13.00 PER DAY FOR DAYS BEYOND 20

POST-HOSPITAL HOME HEALTH SERVICES

- 100 VISITS

COST SHARING - NONE

Chart 16
Hospital Insurance

Coverage under the hospital insurance plan is provided for three types of care furnished by participating organizations: inpatient hospital care, post-hospital extended care, and post-hospital home health services. Coverage became effective for the aged on July 1, 1966, except that the post-hospital extended care benefit did not begin until January 1, 1967. Coverage became effective on July 1, 1973, for the disabled and for people who require dialysis or transplantation due to chronic renal disease. Participating in the Medicare program are about 6,800 hospitals, 3,900 skilled nursing facilities, 2,300 home health agencies, 3,000 independent laboratories, and 800 end-stage renal dialysis facilities.

Inpatient hospital care is covered for up to 90 days in a benefit period (which begins on the day of admission to a hospital, and ends after 60 consecutive days during which the patient is neither a hospital inpatient nor a skilled nursing facility inpatient). The program pays for all but the first $104 of the cost of covered hospital services during 60 days in a benefit period; if hospitalization extends beyond 60 days, it pays all but $26 daily for an additional 30 days. In addition, a lifetime reserve of 60 days of inpatient hospital benefits is available to the beneficiary whenever he has used up the 90 days of hospital benefits in a benefit period. The program pays all but $52 per day for such added days of coverage. Care in mental and TB hospitals is covered, but there is a lifetime limit of 190 days on covered inpatient mental hospital services. The deductible and the copayment amounts are adjusted each year to reflect changes in hospital costs.

Post-hospital extended care (in the kind of skilled nursing home or part of a hospital that qualifies) is covered for up to 100 days in a benefit period if begun within a short time (generally within 14 days) after a hospital stay of at least 3 days. The program pays all covered costs for the first 20 days, and after the 20th day, pays all but $13.00 per day. The copayment is adjusted periodically in the same manner as the deductible and copayment amounts for inpatient hospital services.

Post-hospital home health services are covered for up to 100 visits if furnished within 1 year after discharge from a hospital (after at least a 3-day stay) or, if later, from a skilled nursing facility of which the beneficiary was an inpatient entitled to payment under Medicare and before the beginning of a new benefit period. The services must be provided by a qualified agency, under a plan established and reviewed by a physician. The program pays for covered services in full.

MEDICAL INSURANCE

DEDUCTIBLE -- $60 PER CALENDAR YEAR
COINSURANCE -- PATIENT PAYS 20%

Covered Services

PHYSICIANS' AND SURGEONS' SERVICES

OUTPATIENT HOSPITAL SERVICES

HOME HEALTH SERVICES

- 100 VISITS A YEAR (*WITH NO COINSURANCE*)

OTHER HEALTH SERVICES

Includes:

- OUTPATIENT PHYSICAL THERAPY AND SPEECH PATHOLOGY · CERTAIN CHIROPRACTIC SERVICES · LABORATORY SERVICES · PROSTHETIC DEVICES · RADIATION THERAPY · AMBULANCE · DIAGNOSTIC X-RAYS · OUTPATIENT MAINTENANCE DIALYSIS TREATMENTS

ENROLLEE PAYS $7.20 PER MONTH (EFFECTIVE JULY 1, 1976)

Chart 17
Medical Insurance

The medical insurance plan is open to virtually all persons at age 65, to persons entitled for not less than 24 consecutive months to cash benefits under the social security and railroad retirement programs because they are disabled, and to certain chronic renal disease patients who require hemodialysis or renal transplant. The aged, disabled, and chronic renal disease patients are automatically enrolled as they become entitled to hospital insurance, but are given an opportunity to decline this coverage if they desire. (Residents of Puerto Rico and foreign countries are excluded from automatic enrollment and must initiate action if they wish to enroll.) Beneficiaries pay monthly premiums—$7.20 effective July 1, 1976—that are supplemented by amounts paid by the Federal Government out of general revenues.

Coverage under the voluntary medical insurance plan is provided for physicians' and surgeons' services, outpatient hospital services, home health visits, and a number of other health services. There is an annual deductible of $60, after which the program pays for 80 percent of the reasonable charges for covered services and the patient pays 20 percent, except that payment for home health services is equal to 100 percent of the reasonable cost of services. Program coverage of the services of independently practicing physical therapists is limited to $100 of reasonable charges per calendar year, and there is a special limitation on the total amount the plan will pay for outpatient psychiatric services.

Physicians' and surgeons' services are covered in the home, office, clinic, and hospital.

Outpatient hospital services are covered if furnished by participating hospitals, or in emergencies, by nonparticipating hospitals meeting certain minimum requirements.

Home health services provided by a qualified agency, under a plan established and reviewed by a physician, are covered for up to 100 visits in a calendar year. Covered services include part-time skilled nursing services in the home; physical, occupational, or speech therapy; medical social services; medical supplies (other than drugs and biologicals); home health aide services; and certain medical appliances. The patient must be home bound but no prior hospitalization is required.

Other covered health services include outpatient physical therapy services and outpatient speech pathology services furnished by approved providers; outpatient maintenance dialysis treatments in an approved dialysis facility; certain services of licensed chiropractors; diagnostic tests; dressings, splints, and casts; rental and purchase of durable medical equipment; certain ambulance services; and prosthetic devices (other than eyeglasses, hearing aids, and dentures).

MAJOR BENEFIT EXCLUSIONS UNDER MEDICARE

1. DRUGS
2. CUSTODIAL CARE
3. HEALTH EXAMS, ROUTINE FOOT CARE, IMMUNIZATIONS AND DENTAL CARE
4. ITEMS OR SERVICES NOT MEDICALLY NECESSARY
5. DENTURES, EYEGLASSES AND HEARING AIDS
6. SERVICES BEYOND COVERED LIMITS
7. GENERALLY, ANY SERVICES OR ITEMS IF:

    a. Patient not obligated to pay; or
    b. Provided outside United States, unless services are furnished --
        (i) a beneficiary in certain emergency situations; or
        (ii) a resident of United States in a foreign hospital closer to his residence than the nearest suitable United States hospital, whether or not an emergency exists; or
    c. Payment to be made under workmen's compensation

Chart 18

Major Benefit Exclusions Under Medicare

This chart shows the types of items or services excluded by law from coverage and certain conditions under which any type of item or service is excluded by law. In general, the items or services are excluded because they are not directly necessary for the treatment of illness, or because of cost considerations. Under the Medicare program, primary coverage has been directed toward hospitalization and related care and physicians' and certain other medical services rendered to persons who are ill since these are the health costs that a majority of persons living on limited, fixed incomes find most difficult to finance.

CONTRIBUTION RATE *Schedule*

PERCENT OF COVERED EARNINGS[1/]

	EMPLOYEES & EMPLOYERS (EACH)			SELF-EMPLOYED PEOPLE		
YEARS	FOR OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE	FOR HOSPITAL INSURANCE	TOTAL	FOR OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE	FOR HOSPITAL INSURANCE	TOTAL
1975-77	4.95	0.90	5.85	7.0	0.90	7.90
1978-80	4.95	1.10	6.05	7.0	1.10	8.10
1981-85	4.95	1.35	6.30	7.0	1.35	8.35
1986-2010	4.95	1.50	6.45	7.0	1.50	8.50
2011 and AFTER	5.95	1.50	7.45	7.0	1.50	8.50

[1/] *ANNUAL EARNINGS BASE OF $15,300 FOR 1976 AUTOMATICALLY ADJUSTED TO RISING EARNINGS THEREAFTER*

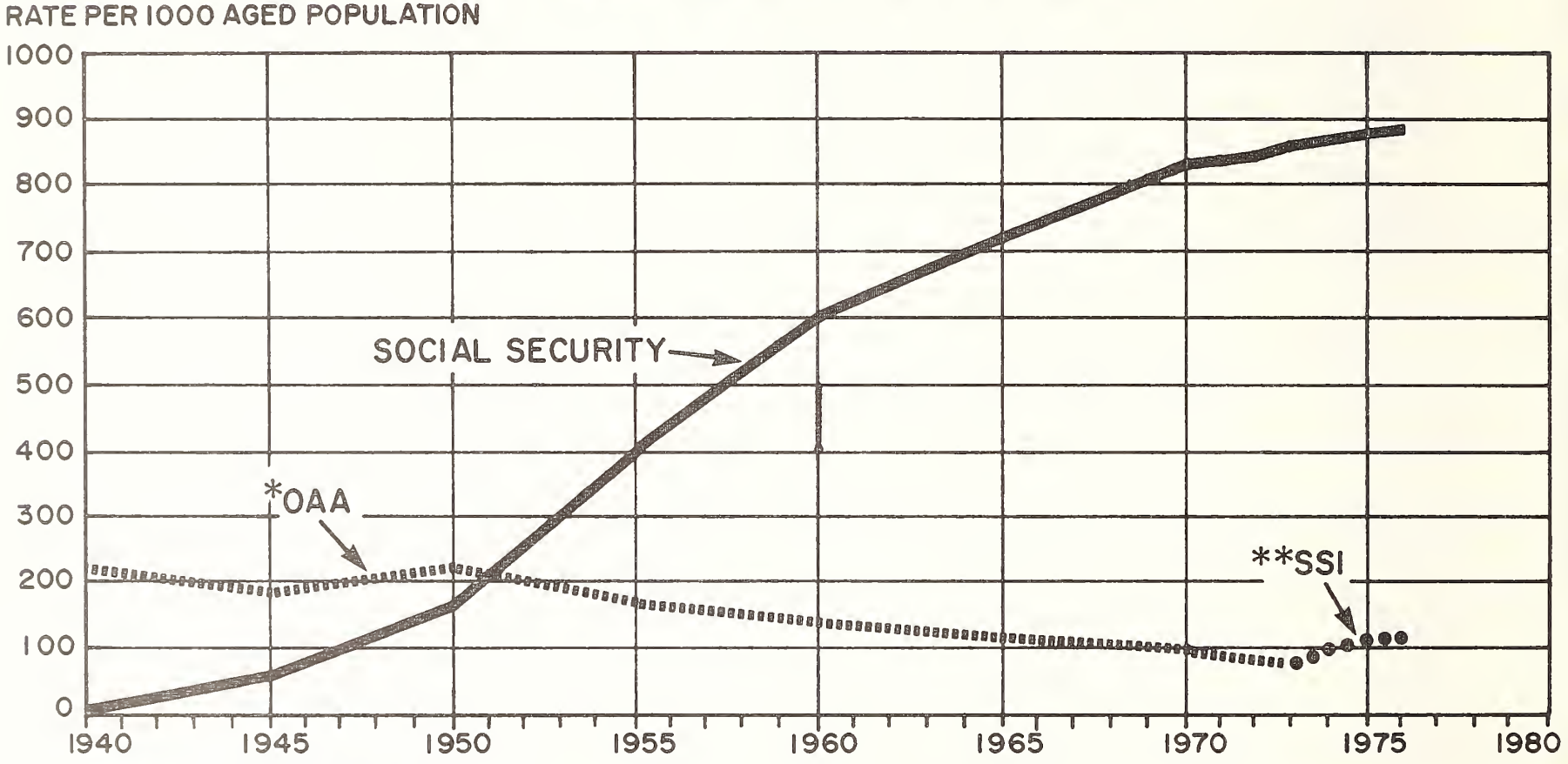
Chart 19

Contribution Rate Schedule

The plan of financing the social security program is as follows: for 1976, employees and self-employed people pay social security contributions on their annual earnings up to $15,300—the maximum amount counted for social security purposes. Each employer also pays social security contributions on the first $15,300 paid to each employee in the year. Annual earnings subject to social security contributions are automatically adjusted to rising wages. The contribution rates are fixed in law. Not reflected in the chart is the supplementary insurance program which is separately financed through voluntary premium payments and general revenues rather than payroll deductions.

This chart shows the schedules of contribution rates specified in present law for cash benefits and for hospital insurance. The financing provisions of the program are intended to produce sufficient income to pay benefits and the administrative expenses of the program and maintain the trust funds at a reasonable contingency-reserve level.

PEOPLE AGED 65 AND OVER: Social Security, OAA* and SSI**



*OLD AGE ASSISTANCE

**SUPPLEMENTAL SECURITY INCOME

Chart 20

People Aged 65 and Over: Social Security, Old-Age Assistance, and Supplemental Security Income

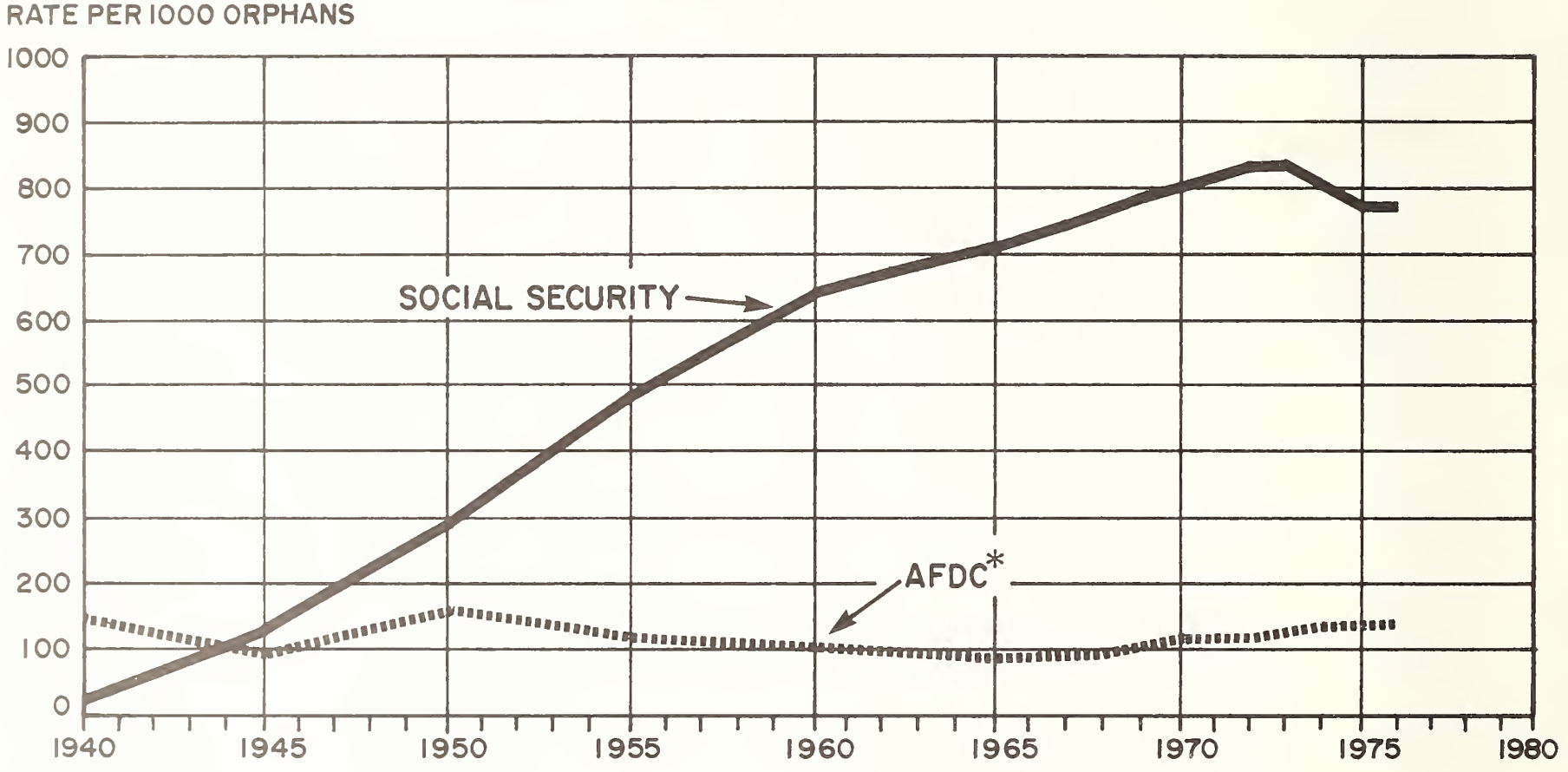
Public assistance is intended to meet whatever need for income remains after account is taken of benefits provided by the social security program and income from all other sources.

Until 1940, the only program of income maintenance for old people in which the Federal Government participated was the old-age assistance (OAA) program. In 1940, while social security was paying benefits to 7 out of every 1,000 persons 65 years of age or older, the OAA recipient rate was 217 per 1,000. The percent of the aged population receiving OAA declined from a high of 22 percent in 1950 to slightly under 10 percent at the end of 1973. During 1951, the social security rate caught up with the OAA rate and has continued to rise rapidly.

The new Federal supplemental security income program, along with state supplementary programs, which became effective January 1, 1974, replaced the Federal-state program of OAA. It is expected that there will be a large increase in the percent of the aged population receiving SSI benefits as compared to the percent of the aged population that received OAA. (See Chart 37 for discussion of increase.)

At the end of 1975, about 887 out of every 1,000 persons aged 65 and over were receiving social security cash benefits while the SSI rate was 100 per 1,000. It is estimated that the respective rates will be 95 and 102 by the end of 1976.

ORPHANS:
Social Security and AFDC*



*AID TO FAMILIES WITH DEPENDENT CHILDREN

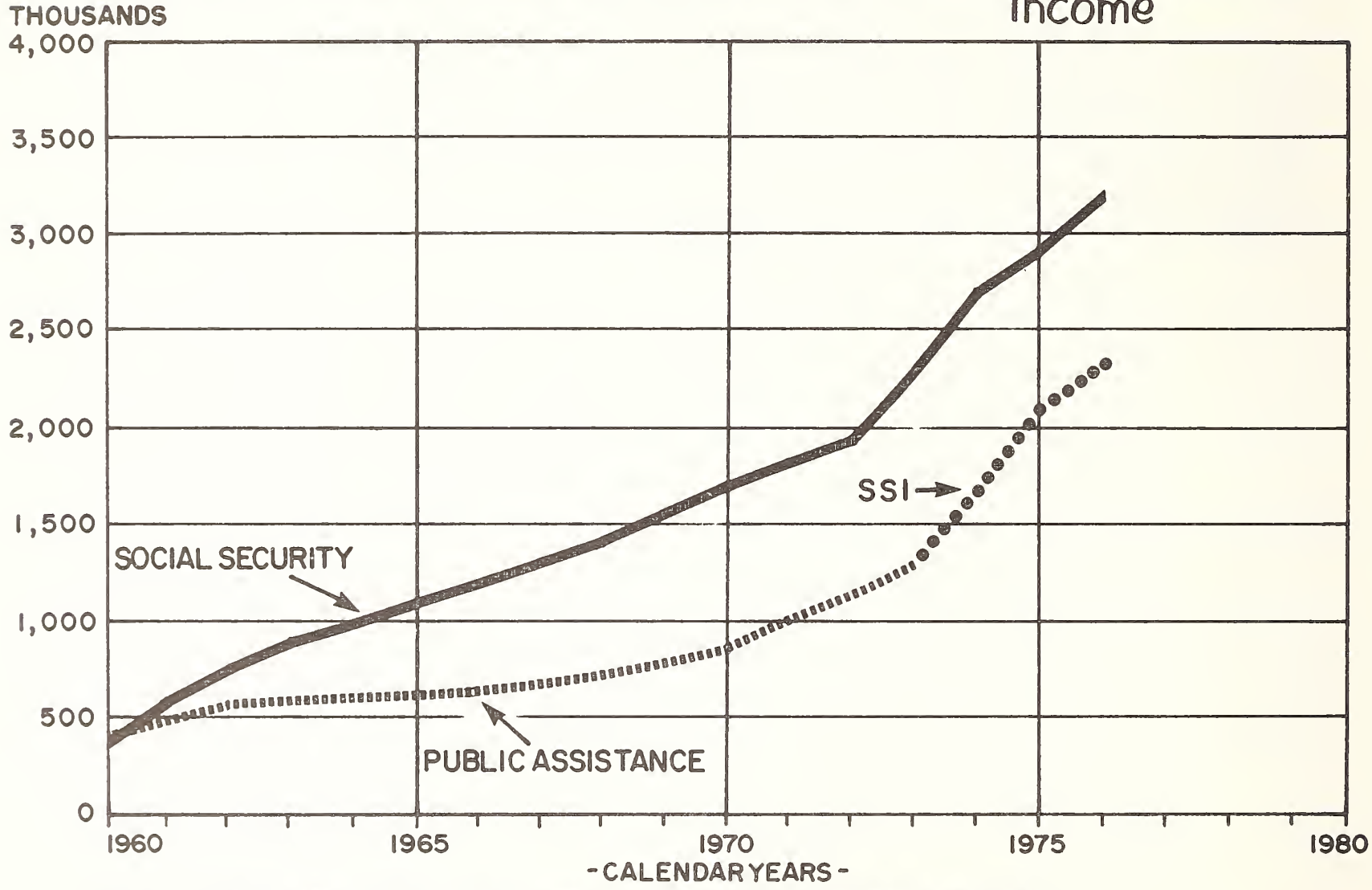
Chart 21

Orphans: Social Security and Aid to Families with Dependent Children

This chart compares the proportion of paternal orphans under age 18 receiving social security benefits with the proportion receiving assistance under the program of aid to families with dependent children (AFDC). Since 1950, the AFDC program as a whole has grown, but the increase has been largely among families in need because of desertion or divorce of the parent rather than death. Only a small proportion of children receiving AFDC are orphans. The number of orphans who receive AFDC has been relatively stable while the number of orphans getting social security benefits has been increasing rapidly. The proportion of paternal orphans receiving AFDC has decreased from 15 percent at the beginning of 1941 to about 14 percent at the beginning of 1976. In this same period, the proportion of orphans getting survivors benefits under social security increased from 2 percent to 76 percent.

DISABLED PEOPLE:

Social Security, Public Assistance* and Supplemental Security Income



*AID TO THE PERMANENTLY AND TOTALLY DISABLED AND AID TO THE BLIND

Chart 22

Disabled People: Social Security, Public Assistance, and Supplemental Security Income

This chart shows how the number of disability beneficiaries under social security (disabled workers, disabled children aged 18 and over, and disabled widows and widowers) has risen faster than the number of recipients under the public assistance disability programs (aid to the permanently and totally disabled (APTD) and aid to the blind (AB)). The chart refers to numbers of beneficiaries, rather than rates per 1,000 of disabled population, because of the lack of consistent data on total number of "disabled" persons in the population over time; definitions of disability vary considerably among programs, surveys, and sources of statistics.

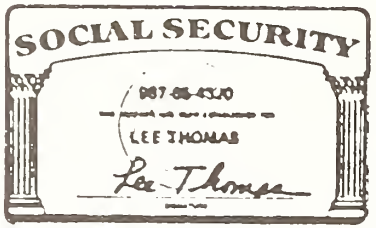
Before 1957, no disability benefits were paid under social security. The payment of benefits to adult disabled sons and daughters of insured workers began in January 1957 and benefits to disabled workers aged 50-64 began in July 1957; by the end of that year, 179,000 people were receiving social security disability benefits. At the same time, 400,000 people were receiving aid under the public assistance disability programs.

Effective January 1, 1974, the new Federal supplemental security income program, along with state supplementary programs, replaced the Federal-state programs of APTD and AB.

As of December 31, 1975, about 2,961,000 beneficiaries (including disabled workers, disabled sons and daughters age 18 and over of disabled, retired, or deceased workers, and disabled widows and widowers) were receiving social security disability benefits; and this figure is expected to rise in the future as the total population increases. This compares with the approximately 2,007,000 blind or disabled recipients of supplemental security income benefits. By the end of 1976, an estimated 3,190,000 beneficiaries will be receiving social security disability benefits and about 2,300,000 blind and disabled will be receiving SSI benefits.

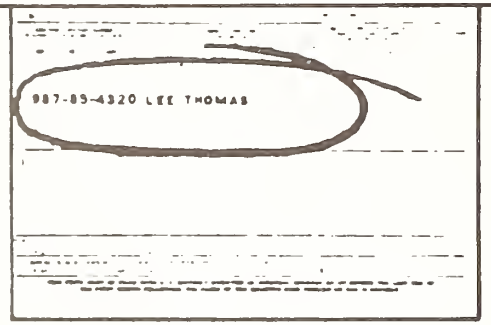
FROM SOCIAL SECURITY NUMBER TO BENEFITS

GETS SOCIAL SECURITY NUMBER



WHILE WORKING

EMPLOYER AND SELF-EMPLOYED REPORT EARNINGS & PAY TAX



SSA

RECORDS EARNINGS

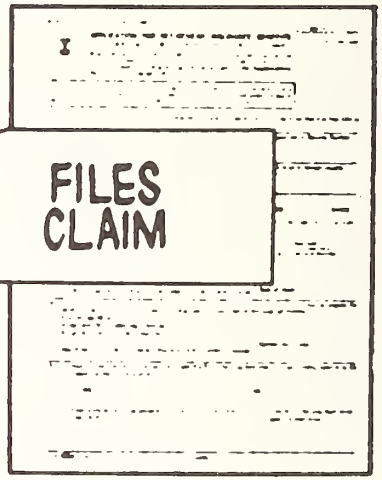
COMPUTES BENEFITS

CERTIFIES PAYMENTS

TREASURY MAKES PAYMENTS

ON RETIREMENT, DISABILITY OR DEATH

FILES CLAIM



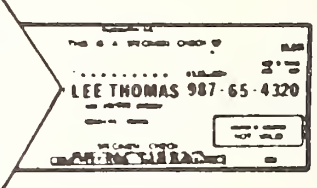


Chart 23

From Social Security Number to Benefits

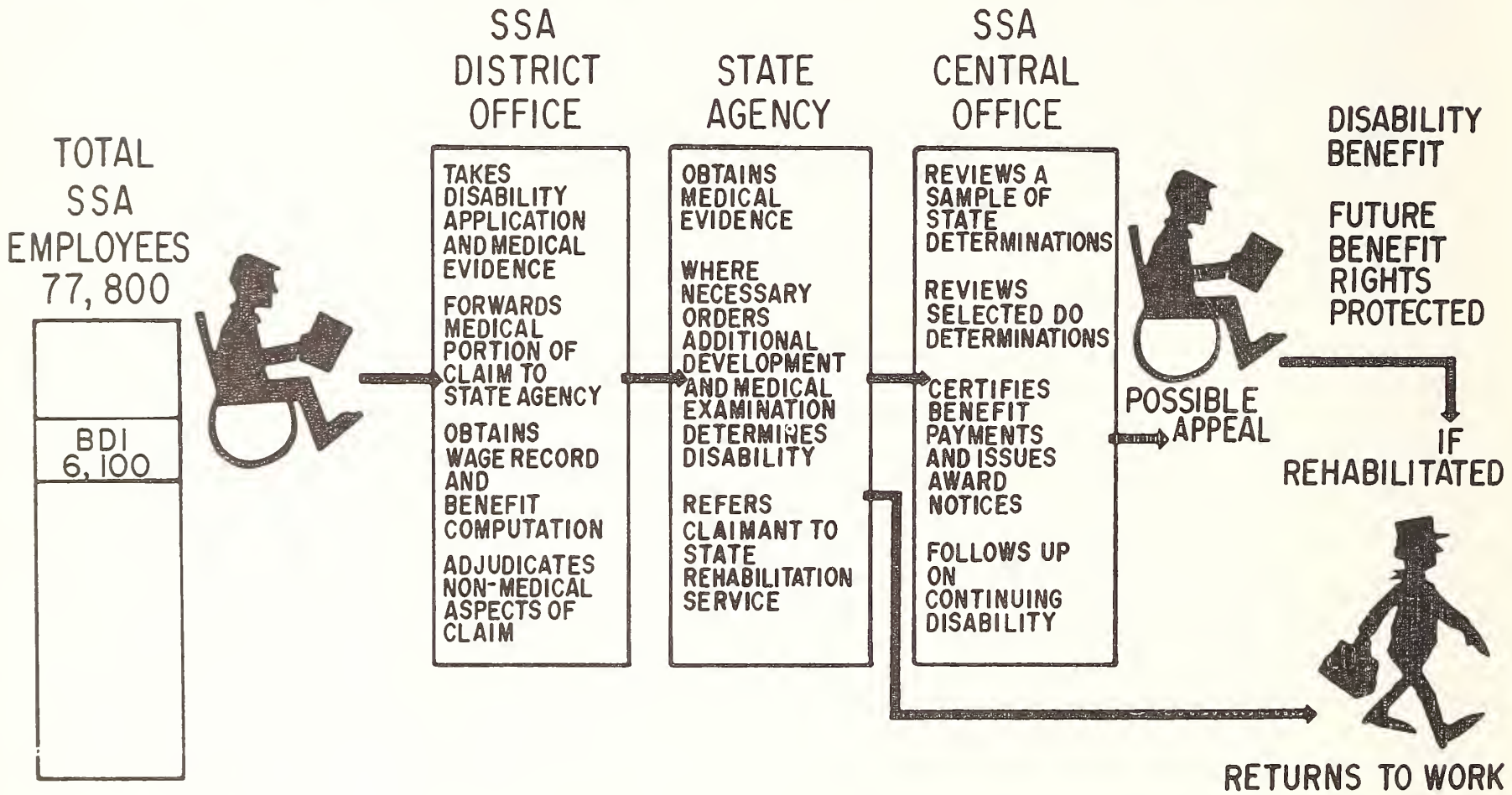
This chart outlines the major functions that are performed in carrying out the social security program.

A person usually gets a social security number (SSN) at a young age, and keeps the number for life. Each employer for whom the person works copies down the name and number, as shown on the card. Every time the employer pays the worker, social security contributions are deducted and, four times a year, the employer makes out a social security return on which is placed the worker's name, SSN, and the amount of wages paid in the particular 3-month period. This return, the social security contributions withheld from the employees, and an equal amount which the employer contributes are sent to the Internal Revenue Service.

The self-employed worker reports earnings and pays social security contributions along with income tax.

In the Central Office of the Social Security Administration (SSA) in Baltimore, the worker's earnings are recorded. When the worker retires, becomes disabled, or dies and a claim is filed, the recorded earnings are used as the basis for figuring the amount of monthly cash benefits for the worker and dependents, or for the worker's survivors. SSA certifies the payment of benefits and the Department of the Treasury either sends the benefit check directly to the beneficiary or makes a direct deposit to a financial institution of the person's choice.

DISABILITY INSURANCE



PERMANENT STAFFING END OF APRIL 1976

Chart 24

Disability Insurance

Disabled workers and their dependents, if they are eligible, disabled dependent children age 18 and over, disabled widows or disabled dependent widowers, aged 50 or over, of workers who were insured at death can receive monthly payments.

This chart shows how SSA and the state agencies (SA) work together in making determinations of disability and in giving consideration to the rehabilitation of disabled applicants under the disability insurance program.

First, the disability claimant, or someone on the claimant's behalf, submits an application and proofs to an SSA district office (DO) for disability benefits. To determine insured status, the DO obtains an earnings record and, if it appears that the claimant is insured for disability and is not engaging in substantial gainful activity (SGA), the claim is forwarded to the SA, more specifically, the Disability Determination Services (DDS) for a determination of disability. The SA evaluates the claimant's medical proofs or contacts the sources of medical information which the claimant has provided. If additional medical information is needed for a decision, the SA arranges for special tests or examinations by a consulting physician. If the claimant is found disabled, the claim is returned to the DO for processing of the award. The DO completes development and adjudication, including any dependent's claim, determines the benefit amount, and forwards the claim to the Bureau of Disability Insurance (BDI) in Baltimore for completion of award processing and certification of payment. (In many cases, the DO may certify payment instead.) If the claimant is not found disabled, the denial letter is, in most cases, released by the SA to the claimant.

Second, after determinations are made and the disabled person is in receipt of disability insurance benefits, followups must be made on the person's continuing eligibility for monthly benefits. Information and notices are received on reentry into employment, completion of vocational rehabilitation, and the like; and investigations and disability determinations are made as necessary. At the end of December 1975, there were 4.35 million beneficiaries—disabled workers and their dependents—receiving benefits.

The state vocational rehabilitation (VR) agencies also determine whether the individual who inquires about disability rights or who makes an application, can be assisted by rehabilitation services. The medical and vocational information in the disability file is used for this purpose. If it is decided that the individual's ability to work can be restored, the agency will work out a rehabilitation plan. Where VR services are refused by a disabled person eligible for monthly benefit payments, the VR agency will notify SSA. Benefits are not payable if the disabled person refuses available rehabilitation services without good cause.

Reimbursements may be made from the social security trust funds to State VR agencies for the cost of rehabilitation services furnished to selected individuals who are entitled to disability benefits. The total amount of such reimbursement in any year may not exceed 1 1/2 percent of the social security disability benefits paid in the previous year. The savings from the amount of benefits that would otherwise have to be paid, and the increased contributions to the trust funds paid by virtue of the earnings of beneficiaries who return to work, exceed the money paid from the trust funds for rehabilitation costs.

HEALTH INSURANCE

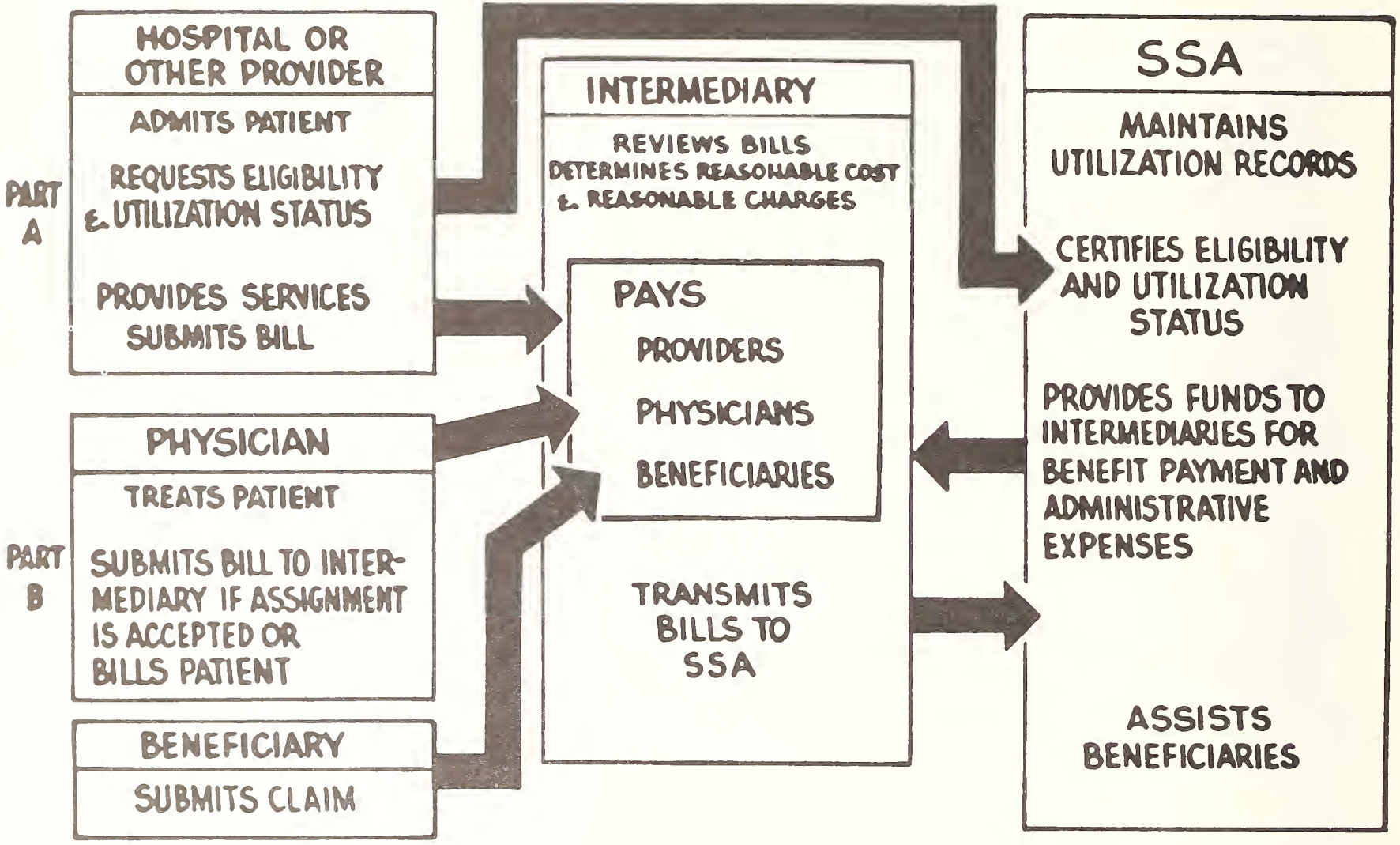


Chart 25
Health Insurance

This chart on the administration of the health insurance program is a simplified picture of a very complex set of operations. In the middle column, for example, we do not distinguish between intermediaries (Blue Cross or insurance company) and carriers (Blue Shield or insurance company) although both the nature of the operation and the volume are quite different. Basically, intermediaries are responsible for the hospital insurance program while carriers are responsible for the medical insurance program.

Ordinarily, a person seeking hospital or medical services under the hospital insurance program, known as Part A, presents his/her health insurance identification card as evidence of eligibility. SSA is then contacted through the intermediary, or directly by the provider, if it has elected not to use an intermediary, and is asked to certify the eligibility of the patient. This certification shows whether or not the patient is eligible, if the deductible amount has been previously paid, and how much of the coverage the patient has previously used. The certification is used to support the bill, which is sent to, and paid by, the intermediary on the basis of reasonable costs or charges (or sent directly to SSA if no intermediary is used). Utilization data are forwarded from the intermediary to SSA to update the health insurance record.

There are limitations on the number of days of care a patient may receive in various health facilities. Since patients may use facilities in various parts of the country, central records of utilization of these facilities must be available to determine eligibility.

Funds for the administrative expenses incurred by the intermediaries for the hospital insurance program and for the payment of services are paid by SSA to the intermediaries.

Coverage under the supplementary medical insurance plan, known as Part B, is provided for physicians' and surgeons' services, home health care, and certain other health services. To be entitled to these payments, the eligible person must be enrolled for Part B coverage and make premium payments. As in the case of Part A, the bill is sent to the intermediary by the patient or doctor (if he has accepted assignment). The intermediary determines whether the charges are allowable and pays the bill with funds provided by SSA.

The chart merely suggests the scope and complexity of administering the health insurance program. Some vital related functions, which do not appear on the chart, are: the establishment of conditions of participation for providers of services; the survey, by SA's under contract with us, of providers to see that they meet present quality levels; the development and maintenance of agreements with about 6,800 hospitals, 3,900 skilled nursing facilities, 2,300 home health agencies, 3,000 independent laboratories, and 800 end-stage renal dialysis facilities; maintaining relationships with the quarter of a million physicians in active practice—most of whom, at some time, treat a Medicare patient; and, the task of collecting premiums from the 24 million persons enrolled in the medical insurance program.

INDIVIDUAL'S RIGHT TO APPEAL...
FOUR LEVELS

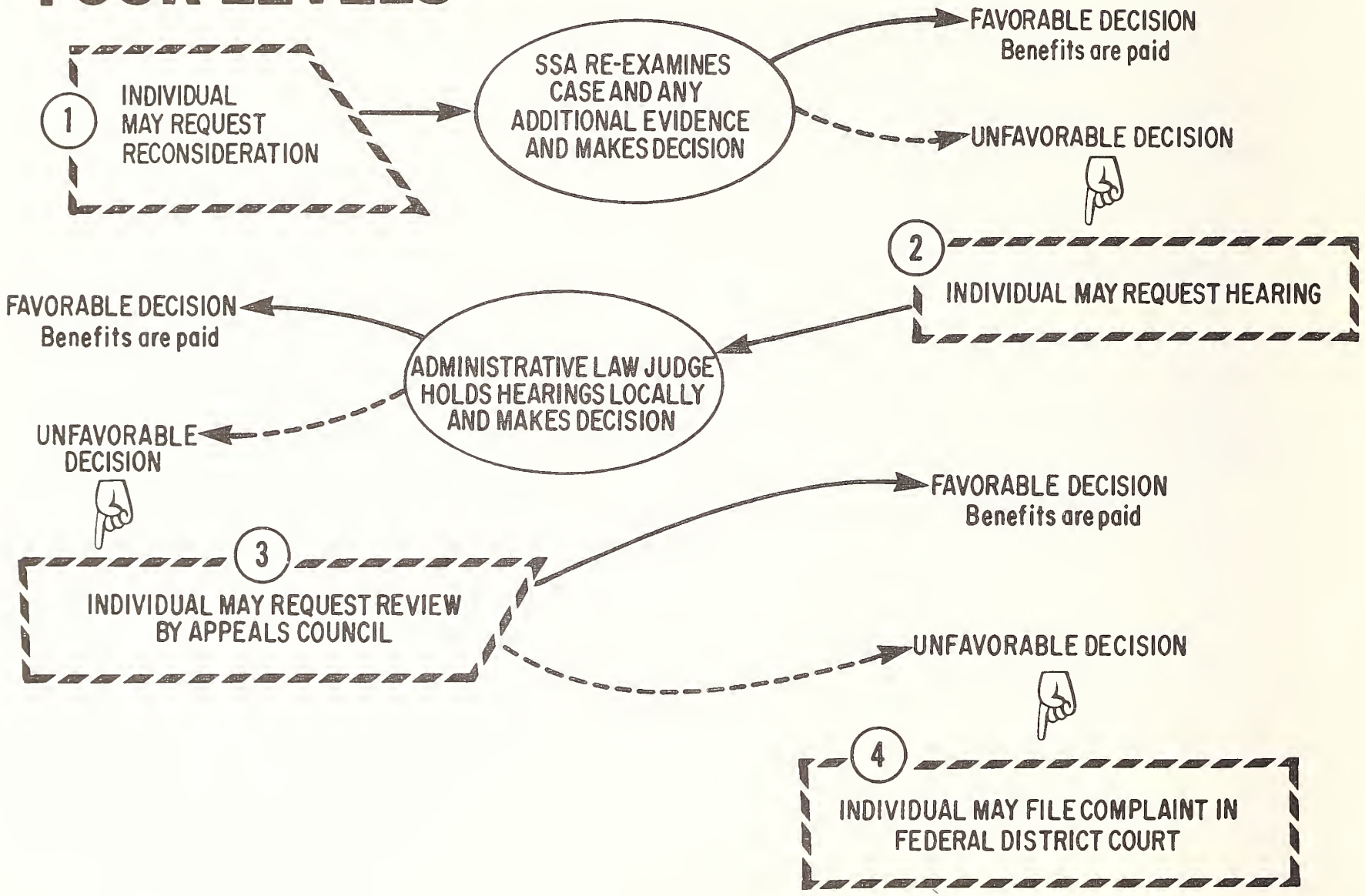


Chart 26
Individual's Right to Appeal

An individual who believes the decision on a claim or on any other of the person's rights under the social security law is incorrect may want to have the decision re-examined. The right to appeal may take the following steps:[1]

Reconsideration

First, an individual, within 60 days from receipt of the determination, may ask SSA to reconsider the determination. The person may at this time submit further evidence in support of the claim. The review is made by persons other than those who made the original determination to insure a new and independent decision. If the claimant disagrees with the decision after reconsideration, within 60 days after receipt of notice of the reconsidered determination, a review at the next level—a hearing before an Administrative Law Judge (ALJ)—may be requested. (In Medicare hospital insurance claims, the amount in controversy must be at least $100 for a hearing before an ALJ.)

Hearing

The ALJ is an officer of the Bureau of Hearings and Appeals of SSA. There are presently about 526 stationed throughout the country. The ALJ has taken no part in any previous decision. A hearing is usually held near the claimant's residence. The ALJ reviews the issues and receives in evidence the testimony of witnesses and relevant documents. The claimant, or the claimant's representative, may question witnesses and present new evidence. To obtain as complete a record as possible in disability cases, arrangements are made for physicians and vocational specialists to appear as expert witnesses. The ALJ's decision is based on the evidence and a written decision is issued affirming, reversing, or modifying the reconsidered decision. If dissatisfied with the decision, the claimant may, within 60 days, request a review at the next level—by the Appeals Council. The request for review may be made within 60 days from the date of mailing of notice of the ALJ's decision or, under Title XVI, within 30 days after receipt of notice of the ALJ's decision.

Appeals Council Review

The Appeals Council, presently consisting of nine full-time members, is also a part of the Bureau of Hearings and Appeals. They meet at bureau headquarters in Arlington, Virginia. The Council may grant review of the ALJ's decision, permit the claimant or the claimant's representative to appear, and issue a decision which affirms, modifies, or reverses the ALJ's decision. On the other hand, the Appeals Council may deny the request for review and the ALJ's decision will stand as the decision of the Secretary, HEW. In either case, the claimant is advised of the right to obtain further review through the filing of a civil action within 60 days in a Federal district court. (In Medicare hospital insurance claims, the amount in controversy must be at least $1,000 for a review by a Federal district court.) The Council, on its own motion, may also initiate a review of an ALJ's decision when it appears the decision is not in accord with the law or regulations or it appears that the findings are not supported by substantial evidence.

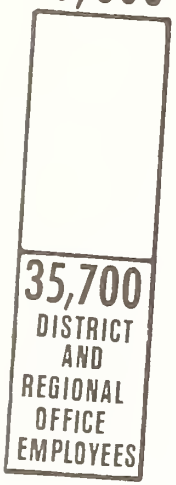
Court Review

When a claimant files a civil action, the Federal district court does not accept new evidence but rather reviews the case on the record. The findings of the Secretary, if supported by substantial evidence, are conclusive on the court. However, upon motion of the Secretary or claimant, or on its own volition, the court may remand the case to the Secretary for further hearing or additional evidence. Upon remand, a decision is filed with the court modifying or affirming the prior decision. If the claimant is still dissatisfied, the claimant may carry his appeal to a higher court. The Secretary has a similar right.

[1]No administrative appeal may be made of disagreements over Medicare supplementary medical insurance benefit payments; however, the individual is entitled to a fair hearing by the carrier.

DIRECT SERVICES TO PUBLIC BY DISTRICT OFFICES EACH MONTH

TOTAL SSA EMPLOYEES 77,800



- TAKE 1,140,000 APPLICATIONS FOR NEW AND DUPLICATE-SSN-CARDS
- RECEIVE 333,000 RETIREMENT AND SURVIVORS CLAIMS
- RECEIVE 153,000 DISABILITY CLAIMS
- PROVIDE ASSISTANCE ON 532,000 HEALTH INSURANCE CASES
- HANDLE 6,863,000 GENERAL INQUIRIES AND POST-ADJUDICATION ACTIONS AND NOTICES

WORKLOADS – MONTHLY AVERAGE, FISCAL YEAR 1975
STAFFING – PERMANENT POSITIONS END OF APRIL 1976

1,300 DISTRICT AND BRANCH OFFICES
3,400 OTHER REGULARLY SCHEDULED SERVICE LOCATIONS

Chart 27

Direct Services to the Public

Social security field offices are located conveniently for the public throughout the United States, Puerto Rico, the Virgin Islands, and Guam. At present, there are about 1,300 district and branch offices with full-time staff ranging from 10 to over 100 people. Employees of these offices also serve some 3,400 itinerant service points on a regular basis—for example, once a week or twice a month one or two employees will have office hours at a post office or other places where there is no full-time office. In many parts of the country it is possible, also, to transact social security business by telephone at no cost to the caller. Field offices perform many services, such as: take and develop claims; give final approval for payment of benefits (and in many cases certify payment also) or disallowance of selected claims; assist beneficiaries in completing medical insurance claims forms; provide identifying information to intermediaries and providers of health services; and provide information on programs and services of other public and voluntary agencies and make referrals to the appropriate agencies.

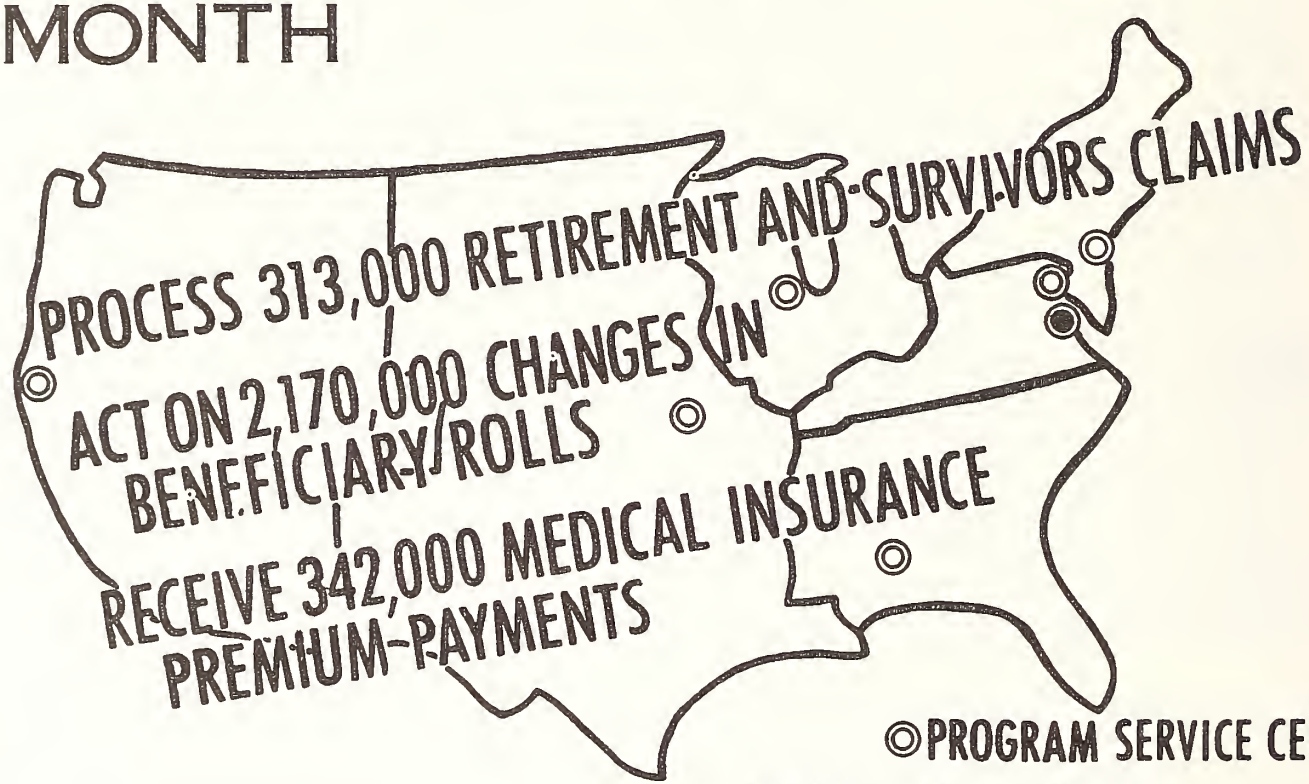
To give some idea of the current volume of work handled by these offices, the chart indicates some of the major workloads. One of the most significant workloads is that of maintaining the beneficiary rolls—handling postentitlement actions. For example, during each month of 1975, the field offices directly put into the computers in Baltimore over 1.3 million actions covering such actions as changes of address.

The field and regional offices have about 35,700 of SSA's 77,800 employees. Field offices are supervised through Regional Commissioners located in the regional offices of the Department of Health, Education, and Welfare.

Social security office employees probably see more people than any other agency of the Government except the Postal Service. Almost everyone will have some contact with a social security office sometime in his/her life. To many, these offices are Uncle Sam, and the quality of the service they give is of the utmost importance to the way people feel about their Government.

PROGRAM SERVICE CENTERS

EACH MONTH



◎PROGRAM SERVICE CENTERS

NORTHEASTERN (NEW YORK)
MID ATLANTIC (PHILADELPHIA)
SOUTHEASTERN (BIRMINGHAM)
GREAT LAKES (CHICAGO)
MID AMERICA (KANSAS CITY)
WESTERN (SAN FRANCISCO)

◉ BALTIMORE -
Div. of International Opers.

WORKLOAD – MONTHLY AVERAGE, FISCAL YEAR 1975
STAFFING – PERMANENT POSITIONS END OF APRIL 1976
(PSC STAFF INCLUDES DIVISION OF INTERNATIONAL OPERATIONS)

Chart 28
Program Service Centers

This chart shows SSA's Program Service Centers.

Here, in six centers located in various parts of the country, we have the work of processing retirement and survivors' insurance (RSI) claims taken by the district offices, adding newly certified claims to the beneficiary rolls, and the gigantic job of maintaining correctly these rolls. In the Division of International Operations, located at Social Security Headquarters in Baltimore, claims and other actions are processed for all beneficiaries living abroad. At the end of December 1975, there were 30.6 million people on the RSI beneficiary rolls and health insurance rolls. This includes 2.2 million people who could not qualify for RSI monthly benefits but who do qualify for Medicare. Of the 30.6 million, 27.4 were receiving monthly RSI benefits. A lot can happen to RSHI beneficiaries in the course of a month. As the chart indicates, there were 2,170,000 monthly changes in the beneficiary rolls. These include: removing beneficiaries no longer entitled because of death, remarriage, child attaining age 18; suspending beneficiaries who return to work and reinstating them when they stop working; increasing benefit amounts to reflect additional earnings; changing addresses; and making adjustments in medical insurance premium payment status.

Within these 2,170,000 monthly changes, there are about 342,000 changes of address, over 202,000 terminations and about 258,000 changes resulting from automatically computed benefit increases due to additional earnings. Other changes processed include termination of benefits to one member of a family group, which changes the amounts payable to other members of the group; changes required when a beneficiary returns to work or stops working; and converting the amount due the 28.4 million people entitled to monthly payments whose benefits are periodically increased by law.

Also, within the average monthly workloads, there are some cyclical workloads, such as: each year, from February to May, the program service centers process about one million annual reports of earnings from beneficiaries whose earnings from work affected the amount of their benefits for the prior year. Also, over 500,000 reports are processed March through May from students age 18-22 verifying whether they will continue to attend school. In addition, the program service centers receive each month about 342,000 medical insurance premium payments from people who are not receiving monthly benefits. (The bulk of the premium collections are made from deductions to monthly benefits.)

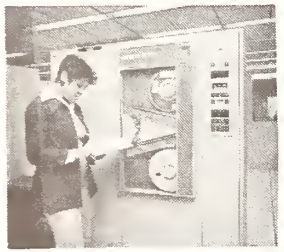
An important point to keep in mind is the great need for accuracy in this operation and for keeping to the time schedule. If it happens that checks in particular locations are a day late in reaching people, serious hardships may result. People need these checks to live on and they have to get them on time and in the right amount. Of the 77,800 SSA employees, 13,800 work in these program service centers and the Division of International Operations.

CENTRAL RECORDKEEPING AND DATA PROCESSING

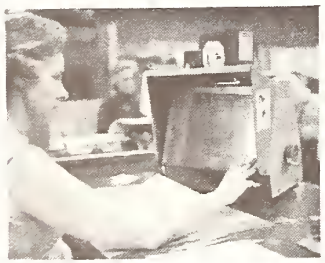
TOTAL SSA EMPLOYEES 77,800

BDP 10,600

SYSTEMS CONSOLES



TELECOMMUNICATIONS



MICROFILM

EACH MONTH

- ESTABLISHES 620,000 NEW SSN'S
- COMPUTES 550,000 INITIAL BENEFITS
- MAINTAINS MASTER ROLLS FOR 36 MILLION PEOPLE (32.5 Million currently receiving monthly benefits)
- POSTS 2.5 MILLION HEALTH INSURANCE BILLS TO UTILIZATION RECORDS
- RESPONDS TO 6.5 MILLION HI QUERIES

EACH 3 MONTHS

- RECORDS 98 MILLION EARNINGS ITEMS

WORKLOAD – AVERAGE FISCAL YEAR 1975 (HI FOR CY 1975)

STAFFING – PERMANENT POSITIONS END OF APRIL 1976

Chart 29

Central Recordkeeping and Data Processing

The magnitude of some of the major recordkeeping workloads for the social security programs is indicated on this chart.

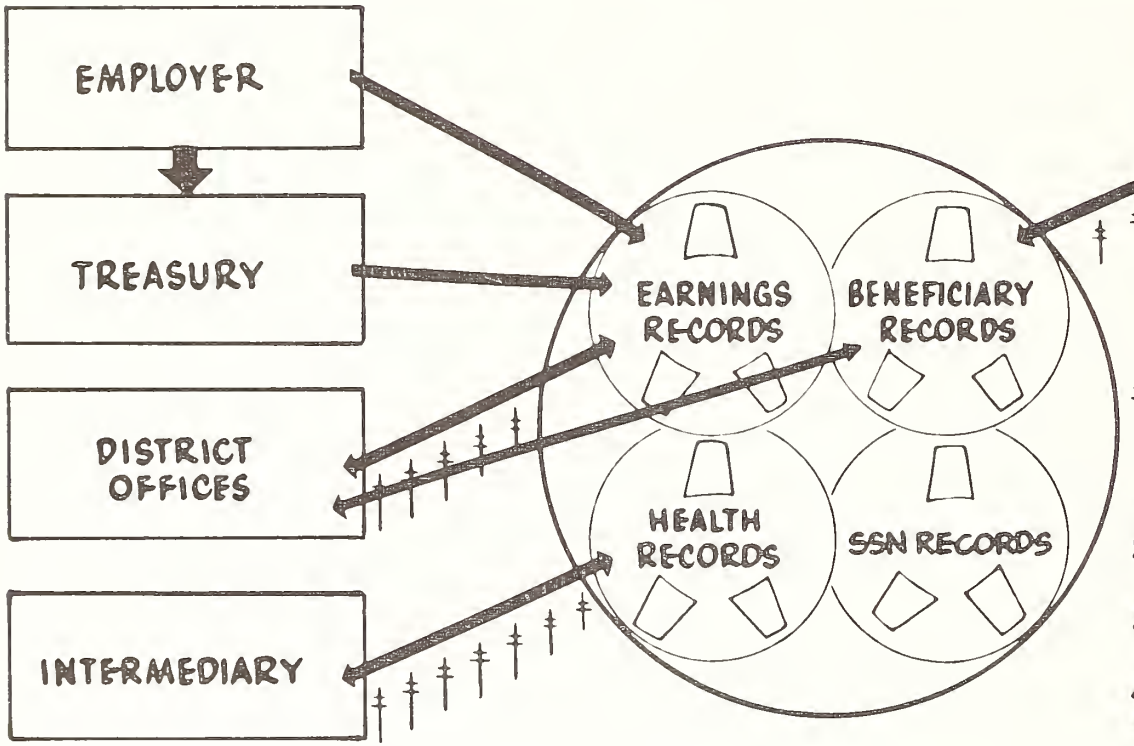
Specifically tailored systems and programs maintain, utilize, and generate records on millions of individuals for various purposes through computers. In 1975, over 100 million people will contribute to social security, and the wages and self-employment income that they earn in covered employment will be added to the lifetime earnings records on which their benefits will ultimately be based. At the end of December 1975, 36 million people were on the rolls because of retirement, disability, or as survivors of deceased workers or uninsured people enrolled in the health insurance program. Of these, 32.5 million were receiving cash benefits each month. Through our central records maintained in the Bureau of Data Processing (BDP), we are able to identify those individuals who are age 65 and apparently eligible for benefits but who have not claimed them; by a record-linkage system with the Internal Revenue Service, we are frequently able to obtain their current address and invite them to claim what is due. We earmark our records so that we are also able to identify those people who are receiving benefits regularly, but who should not be receiving full payment because they are working and exceeding the earnings limitation imposed by law. While most people—about 90 percent—understand the earnings limitation and report accordingly, the remaining 10 percent are investigated through this system. In addition, data is derived from the central records for program analysis and statistical purposes. These computerized activities form the backbone of social security recordkeeping operations. The basic records are maintained on magnetic tape and are updated electronically at high speeds. Visible records are also produced on printouts and microfilm.

Microfilm is used extensively to keep paper files at a minimum. Records in readable form are produced as an integral part of computer operations, from magnetic tape to microfilm, without an intervening paper printout. Summary data is retained on magnetic tape, enabling many operations to be processed completely by computers without reference to detailed data. Selected microfilm records are supplied to program service centers and microfiche records to social security offices and health insurance intermediaries for use in their operations.

All of these records are maintained basically for the operation of the social security program. But they yield a number of other benefits to Government, industry, and commerce. For example, the social security number is used by the Civil Service to identify Federal employees, by Internal Revenue Service to identify taxpayers, and by some states to identify welfare recipients.

Statistically, where disclosure of data on an individual is not involved, social security records are a storehouse of information. They not only reduce the amount of information businesses might have to furnish to other agencies, but also provide both businessmen and researchers with valuable information. For example, the Annual County Business Patterns derived as a byproduct of operating statistics show how many people work, where, and in what industries. Market analysts find it invaluable. In another area, the health insurance master tape record will supply information on utilization of health services, on costs and charges, and on characteristics of all persons and providers of services.

CENTRAL RECORDS
THE HUB OF A NETWORK



CENTRAL DATA TAPE RECORDS ARE USED FOR:

1. IDENTIFICATION OF ALL SSN'S
2. MAINTENANCE OF LIFETIME EARNINGS RECORD
3. ESTABLISHMENT OF ELIGIBILITY FOR BENEFITS
4. COMPUTATION OF BENEFITS
5. RECORDING HEALTH INSURANCE UTILIZATION
6. RECORDING PREMIUM PAYMENTS
7. PROVIDING LEADS TO POTENTIAL CLAIMANTS

WIRE NETWORK PROVIDES RAPID ACCESS AND PROVISION OF INFORMATION WHERE NEEDED

Chart 30

Central Records—The Hub of a Network

A nationwide telecommunications network links district offices, regional offices, program service centers, and Headquarters. Intermediaries under the health insurance program also have access to the system. Data are exchanged between Social Security and the Railroad Retirement System. Direct access to the computers by telecommunication permits maximum centralization of electronic data processing, and speeds the processing of claims, the updating of benefit records, and the rapid supply of utilization and benefit information to requesters.

Four major classes of records are maintained as subsystems of what is essentially a unified single system. The first major record is the social security number (SSN) file that individually identifies participants in the program. Name files are also maintained to facilitate furnishing of duplicate cards and proper crediting of incorrectly reported wages. Because of name changes, mostly by women when they marry, the name files are substantially larger than the number files. Almost 235 million SSN's have been established since the program began in 1937. At the beginning of 1976, there were about 181 million living persons with SSN's.

The second major record is the lifetime earnings information maintained individually for each contributor to the program. It is kept current by quarterly earnings reports made directly to the Social Security Administration by employers on magnetic tape, by the quarterly employer tax reports made through the Internal Revenue Service, and by self-employed who report their earnings on their income tax returns to Internal Revenue. The earnings record is the basis for determining insured status when a person retires, becomes disabled, or dies, and for determining the amount of monthly benefits. The records are also used as a source of leads to potentially eligible individuals who may not be aware of their rights to benefits. These leads are identified by computer examination of the record and transmitted to the district offices.

The third major record is the beneficiary roll. Individual beneficiary files are kept in the program service centers, but magnetic tape rolls for each are maintained centrally using computers linked by a high-speed data transmission system to EDP equipment in the program service centers. Treasury Disbursing Centers prepare and issue benefit checks, or make direct deposits to a financial institution should a beneficiary request it, from magnetic tapes prepared in the data processing center and forwarded through the program service centers.

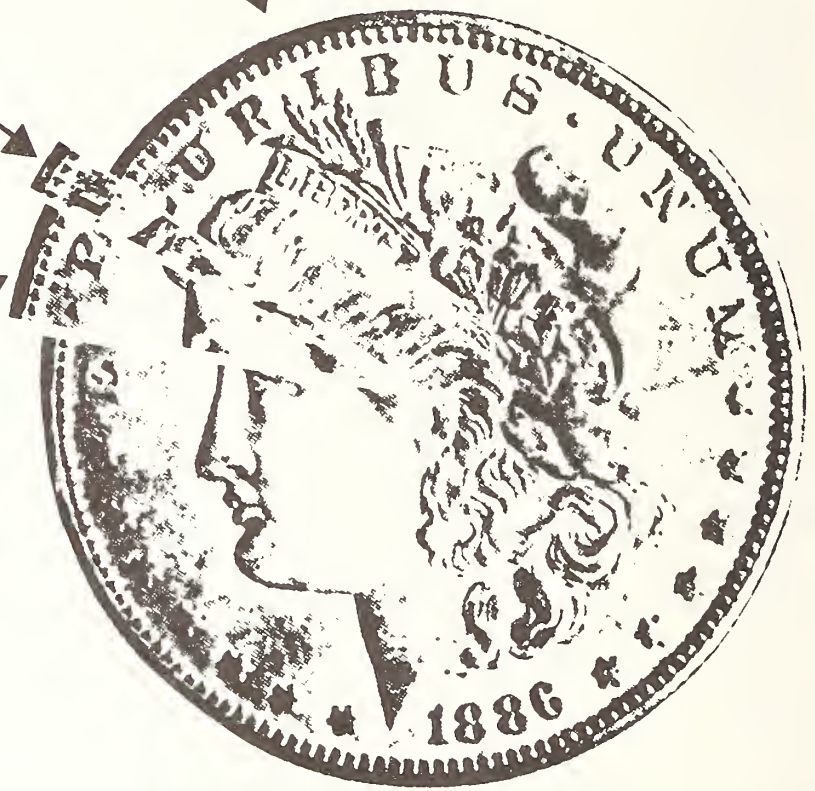
The fourth major record is the health insurance roll. Twenty-three million persons age 65 and over are covered by the basic hospital insurance program. Over 96 percent of these people are also enrolled in the voluntary medical insurance program. Premium payment information is also maintained for those people enrolled in the voluntary program.

HOW THE SOCIAL SECURITY DOLLAR IS SPENT

BENEFITS 92.9¢

ADMINISTRATION
2.1¢

NEW INVESTMENTS
5.0¢



FISCAL YEAR 1975

Chart 31

How the Social Security Trust Fund Dollar is Spent

The main sources of income to the social security programs are contributions on earnings, premiums from enrollees in the supplementary medical insurance program, and Federal payments matching the premiums. This income can be used only for the payment of benefits and administrative expenses of the program. Income not needed for current benefits and administrative expenses is invested in interest-bearing obligations of the United States and in obligations issued by certain federally-sponsored agencies.

The social security program operates at a low cost; most of the outgo from the trust funds represents payments to beneficiaries. In fiscal year 1975, $1.8 billion was spent for operating expenses, and $76.7 billion for retirement, survivors, disability, and health insurance benefits. The increase in the reserves of the social security trust funds during fiscal year 1975 was $4.1 billion.

The amount spent for administration includes the charge made against the trust funds by the Treasury Department for collection of contributions, writing checks, and management of the trust funds' investments in U.S. Government securities. It also includes the expenses of health insurance contractors and state agencies assisting in the administration of the Medicare program and of the state agencies assisting in the administration of the disability insurance program. The amount of benefit payments shown above for fiscal year 1975 includes the cost of vocational rehabilitation for disabled beneficiaries. It excludes the administrative cost of the SSI and Black Lung Programs which are paid from general revenues.

A trust fund breakdown of the administrative expenses for each income dollar is as follows:

Old Age and Survivors Insurance Trust Fund	1.4 cents
Disability Insurance Trust Fund	2.9 cents
Hospital Insurance Trust Fund	2.1 cents
Supplementary Medical Insurance Trust Fund	10.0 cents

SOCIAL SECURITY IN REVIEW

RSDHI PROGRAM
MAJOR CHARACTERISTICS

- BENEFITS EARNED THROUGH WORK
- CONTRIBUTORY
- NO NEEDS TEST
- GENERALLY COMPULSORY
- WEIGHTED BENEFITS
- BENEFIT RIGHTS DEFINED BY LAW

OPERATIONS
MAJOR CHARACTERISTICS

- INDIVIDUALIZED SERVICE THROUGH DISTRICT OFFICES
- MASSIVE DATA PROCESSING OPERATIONS

Chart 32

Social Security In Review

The first principle of the program is that economic security for the individual grows out of his/her own work. Entitlement to monthly cash benefits and the amount that will be paid are related to a person's earnings in covered work, on which social security contributions are paid. The fact that workers pay contributions to help finance the benefits encourages a responsible attitude toward the program. The more that people earn under the program, the higher their benefits will be and, because eligibility for benefits does not depend on one's meeting a needs test, people are encouraged to build upon their basic social security protection. These characteristics of the program are in harmony with traditional economic incentives.

The fact that benefits are not subject to a needs test is, in itself, an important principle. People can count on having not only social security, but also whatever supplemental protection they can build in the form of income from savings, pensions, investments, and the like.

Another important principle of social security is that the coverage of the program be universal and compulsory. In almost all cases, social security coverage is an automatic accompaniment of holding a job.

Another principle is that the program is designed to accomplish social objectives. For example, since lower paid workers have less margin for reduction in their earnings than higher paid workers, benefits are weighted in favor of the lower paid worker—that is, higher benefits relative to previous earnings are paid to the lower paid worker than to the higher paid worker.

Also, another characteristic of the social security program is that an individual's rights to benefits—how much he/she gets and under what conditions he/she gets it—are clearly defined in the law. A person who meets the conditions for receipt of benefits provided in the law must be paid; decisions of the administering agency can be appealed to the courts.

Many of the people covered under social security were already middle-aged or older when the program began. To make the program quickly effective in providing security for these people, the amount of a person's benefit is based on average monthly earnings during a period over which he/she could be expected to have worked in covered jobs. Without such a provision, the advantages of an effective retirement program would have been postponed for many years; older workers would not have had benefits even nearly approaching adequacy when they retired.

The two major characteristics of operations—massive data processing operations on the one hand and individualized service on the other—reflect a unique combination of what may be regarded as two extremes. The achievement of high standards of performance in each merits equal attention.

The huge volumes of work that SSA must deal with can be handled efficiently and economically only through mass production approaches using the most up-to-date technology in sophisticated systems arrangements. And, since we cannot ever be satisfied with what we have achieved, about 1,020 full-time methods and systems people systematically and continuously evaluate all the operations, identifying and solving problems and developing new and approved approaches.

On the other hand, dealing with people who are protected by the program is a very individualized and personal matter. Everyone who deals with social security is deserving of respect and entitled to courteous, friendly, helpful, individualized service. It is in the local social security offices that the program most often meets individuals face-to-face. Social security office employees are especially trained to deal sensitively with the special needs of the person just retiring, the wife or mother who has just lost a husband, and the man or woman who is disabled. For the people with whom we deal, the visit to the social security office is often accompanied by fears and uncertainties deriving from the crises or turning points that have taken place in their lives. We seek to serve them in ways that befit their dignity as individuals and that are fully appropriate to the nature and purpose of the social security program.

OUTLINE OF PRESENTATION ON SUPPLEMENTAL SECURITY INCOME PROGRAM

WHAT IT IS	WHO IS ELIGIBLE	HOW MUCH PEOPLE GET	HOW WE OPERATE

Chart 33

Outline of Presentation on Supplemental Income Program

This chart outlines the subjects covered in this presentation.

SUPPLEMENTAL SECURITY INCOME FOR THE AGED, BLIND, & DISABLED

1. EFFECTIVE JANUARY 1, 1974, A BASIC INCOME LEVEL FINANCED FROM GENERAL REVENUES

2. NATIONALLY UNIFORM ELIGIBILITY STANDARDS

3. ADMINISTERED BY THE SOCIAL SECURITY ADMINISTRATION

4. STATE REIMBURSES FEDERAL GOVERNMENT FOR PAYMENTS ABOVE THE FEDERAL BASIC AMOUNT MADE FOR THE STATE BY SSA (FEDERAL GOVERNMENT ASSUMES ADMINISTRATIVE COSTS AND PROTECTS STATES FROM COST INCREASES DUE TO INCREASES IN THE NUMBER OF ELIGIBLE PERSONS)

Chart 34

Supplemental Security Income for the Aged, Blind, and Disabled

The supplemental security income (SSI) program establishes for the first time in this country a wholly federally financed and administered program of aid for the aged, blind, and disabled. This is of major social importance. The new program, effective since January 1974, provides a Federal floor of income for eligible aged, blind, and disabled persons in the 50 states and the District of Columbia. Nationally uniform eligibility requirements replaced the multiplicity of requirements that existed in the Federal-State welfare programs for the aged, blind, and disabled that were administered by state and local agencies.

A great deal of discussion preceded the decision on the title of the new program. The title finally decided on—supplemental security income—makes explicit the fact that these benefits will in most cases supplement income from other sources, including social security benefits. In future years, approximately 90 percent of aged people (the largest category who receive SSI) will also receive some social security benefit.

The Federal floor of income established by the new program is intended to be a base. States that in December 1973 maintained their public assistance recipients at higher income levels than the Federal base are required (as a condition of receipt of Federal matching funds for Medicaid) to supplement the Federal payments to maintain their recipients' higher December 1973 income levels. (Because of a State constitutional prohibition, Texas is excluded from this requirement.) Some states are also providing supplementary payments to people who were not previously on state public assistance rolls. Those states that have elected Federal administration of the supplements are protected by means of a Federal guarantee against increases over their 1972 costs for welfare payments to the aged, blind, and disabled due to increases in the numbers of eligible persons. The Federal Government assumes administrative costs for states agreeing to have SSA make payments on their behalf.

BASIC ELIGIBILITY CONDITIONS

- **AGED** — 65 OR OVER
- **BLIND / DISABLED** — SOCIAL SECURITY DISABILITY INSURANCE DEFINITIONS
- **COUNTABLE INCOME** — BELOW $503.40 A QTR. FOR AN INDIVIDUAL, $755.40 FOR A COUPLE (EFFECTIVE 7/76)
  (NOT COUNTING $60 A QTR. OF ANY EARNED OR UNEARNED INCOME AND $195 PLUS HALF OF REMAINDER OF EARNED INCOME)
- **COUNTABLE RESOURCES** — $1500 FOR AN INDIVIDUAL
  $2250 FOR A COUPLE
  (NOT COUNTING A HOUSE, HOUSEHOLD GOODS, CAR, PERSONAL EFFECTS OF REASONABLE VALUE)

Chart 35
Basic Eligibility Conditions

The SSI program covers people aged 65 and over, and blind and disabled people of any age who meet the income, resources, and other requirements.

For the blind and disabled, generally the same definitions of disability and blindness as used in the social security disability insurance program are used for determining eligibility for the SSI program. People on state rolls for assistance to the blind in December 1973 who met state definitions in effect in October 1972 are considered blind for purposes of the SSI program. People on the state rolls for aid to the disabled for a month before July 1973 and also for December 1973 are considered disabled under the SSI program.

Limits on income for purposes of eligibility are $503.40 a quarter for an individual and $755.40 a quarter for a couple effective July 1976 ($473.10 for an individual and $709.80 for a couple during the period July 1975 through June 1976). However, in computing the amount of an individual's or couple's income, $60 per quarter of any kind of income is not counted. Thus, in effect, all social security beneficiaries, and those who have other income, are guaranteed, effective July 1976, quarterly total incomes of not $503.40 for an individual but $563.40, and not $755.40 for a couple, but $815.40. Also, there is an additional quarterly disregard of earned income of $195 and above that the deduction for earned income is $1 for $2. (If an individual's only source of income is from earnings, then the basic quarterly disregard would be $255 (the $60 and $195 combined) plus one-half of any additional earnings.) Blind people also have work expenses excluded. Blind or disabled people with an approved plan of self-support have additional amounts of income excluded.

In addition, there are uniform limits on resources of $1,500 for an individual and $2,250 for a couple. The home a person lives in and owns is not counted, as long as it does not exceed a current market value of $25,000 ($35,000 in Alaska and Hawaii). An automobile worth less than $1,200 is not counted. Household goods and personal effects of a total market value of less than $1,500 are not counted. Life insurance policies whose total face value per insured eligible person does not exceed $1,500 are not counted. Resources necessary for self-support which yield specified rates of income and whose value is within tolerances are not counted.

GRANDFATHERING STATE PROGRAM PROVISIONS*

- BLIND AND DISABLED (DISABLED WHO WERE ALSO STATE RECIPIENTS PRIOR TO JULY 1973) WHO CONTINUE TO MEET STATE DEFINITIONS*
- HIGHER STATE RESOURCE LIMITATIONS CONTINUE*
- HIGHER STATE INCOME DISREGARDS FOR BLIND CONTINUE*
- ESSENTIAL PERSON**

*Must meet October 1972 State Plan

**Must meet June 1973 State Plan

Chart 36

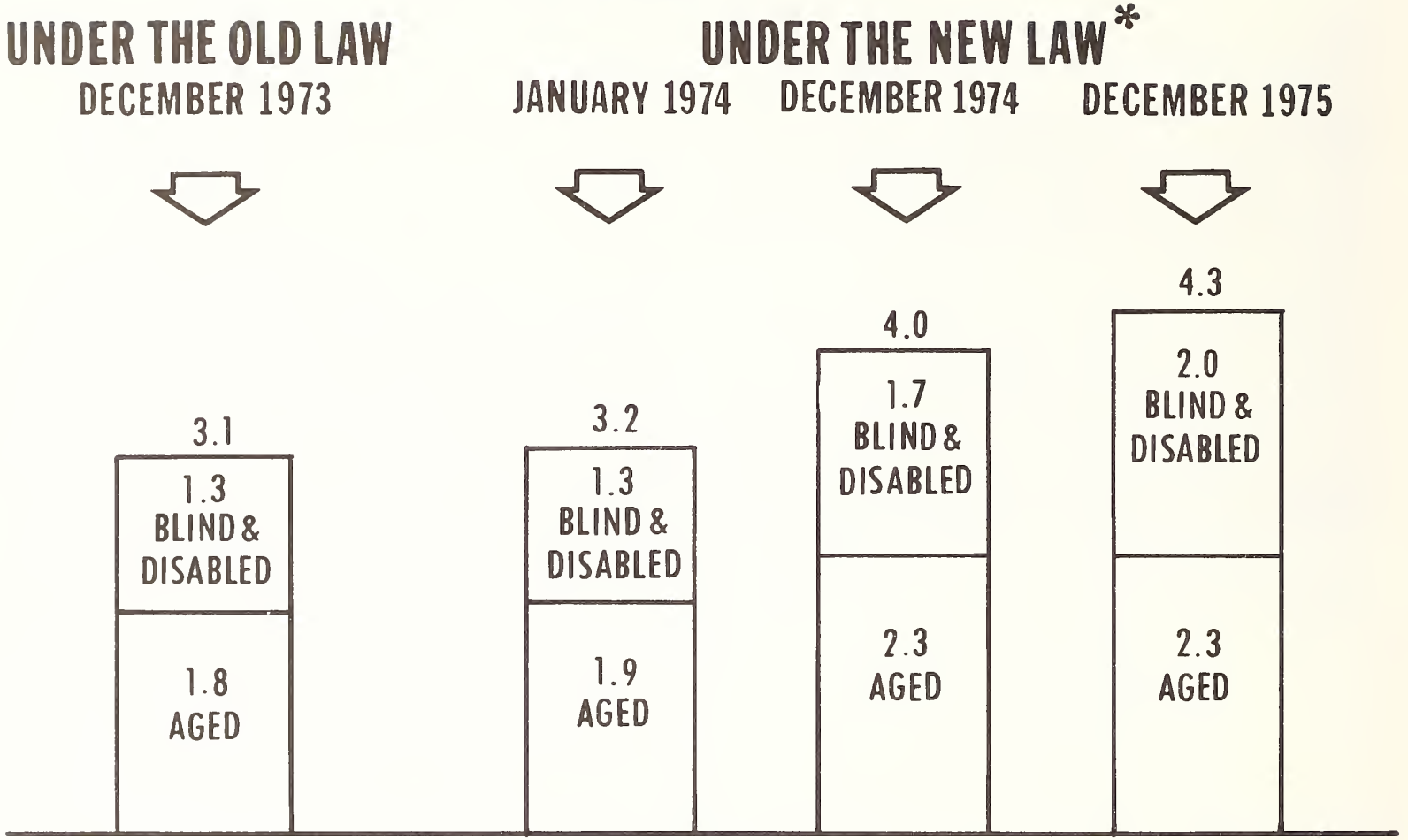
Grandfathering State Program Provisions

Blind people who received public assistance payments from the state for December 1973 do not have to meet the definition of blindness in the Federal law in order to be considered blind for purposes of the Federal program. They are deemed to meet the Federal definition so long as they continue to meet the blindness definition that was set forth in the state plan as of October 1972. Disabled people on the state rolls for aid to the disabled for December 1973 are considered disabled under SSI, but only if they also received such aid for at least 1 month before July 1973.

If the state resource limitations in effect in October 1972 were higher than the Federal limitations, the state limitations will continue to apply for recipients who were on the state rolls for December 1973. Similarly, where the state income "disregard" in effect for October 1972 for a blind person is higher than the Federal disregard, the state disregard will continue to apply to blind people who are on the state rolls for December 1973. The state's resource limitation for the aged, blind, and disabled and income disregards for the blind will apply only for as long as the recipient remains continuously a resident in the state in which he was getting assistance in December 1973 and continuously eligible for SSI (except that periods of ineligibility of no more than 6 months will not be counted).

State assistance recipients who in December 1973 were receiving payments which took account of one or more essential persons in the household can be eligible for an increased monthly benefit standard under the SSI program. Effective July 1976, the increase in the benefit standard is $84.00 per month for each essential person ($78.90 during the period July 1975 through June 1976). An essential person is one whose needs were taken into account under the old state plans (as in effect for June 1973) as persons whose presence in the household was considered necessary to provide care and essential services for public assistance recipients. Eligibility for such increased payments under SSI applies only in the case of a person included as an essential person for December 1973 and will cease at such time as the person no longer lives with the eligible individual, becomes eligible for SSI in his or her own right, or becomes the eligible spouse of an eligible individual. Income and resources of an essential person are deemed to the eligible individual or eligible spouse.

RECIPIENTS
(IN MILLIONS)



* Includes recipients of Federally administered state supplements who are not eligible for Federal payments because of their incomes.

Chart 37
Recipients

The new Federal program has brought more people into the program than received payments under the Federal-state programs. It is estimated that as of January 1974 under the former state public assistance programs, about 1.3 million blind and disabled people and 1.8 million aged people would have received benefits. As this chart shows, there has been and there will continue to be an increase in the number of aged, blind, and disabled receiving benefits under the new Federal system.

The primary reasons for the increases are: first, the Federal program will pay many people who were not eligible for state assistance because they had too much income or resources, or because their states had relative responsibility requirements; second, many people who actually met the state requirements did not apply for public assistance payments in states which had lien laws. Since the Federal law has neither lien nor relative responsibility provisions, more people are expected to apply.

About 260,000 of the 3.2 million recipients for January 1, 1974, received only State supplementation to bring the level of their income up to state standards that are higher than the Federal standard. This number increased to 344,000 in December 1974 and 415,000 in December 1975.

MONTHLY PAYMENTS

EFFECTIVE JULY 1976

$ 167.80 ◇ FOR AN INDIVIDUAL

$ 251.80 ◇ FOR A COUPLE

- **If no income - full payment**
- **If other income - payment reduced by $1 for each:**

  $1 of <u>unearned</u> income over $20 -

  $2 of <u>earned</u> income over $65 -
  (or over $ 85 if no unearned income)

☞ *Income and SSI amounts are figured on a quarterly basis and monthly payments are arrived at by prorating quarterly figures.*

Chart 38
Monthly Payments

Effective in July 1976, the basic monthly amount for a person who meets the eligibility requirements and has no countable income at all is $167.80 for an individual and $251.80 for a couple both of whom are eligible. (For the period July 1975 through June 1976, these amounts were $157.70 for an individual and $236.60 for a couple.) As with social security benefits, SSI benefits may be automatically increased to reflect increases in prices, thereby protecting the purchasing power of the SSI benefits.

If the individual or the couple has unearned income—that is, social security benefits, pensions, regular contributions from relatives, or other unearned income—the first $20 is not counted; the basic monthly SSI amount is reduced by $1 for each additional dollar of this income.

In the case of earned income, the first $65 is not counted and the basic monthly SSI amount is reduced by $1 for each additional $2. If there is no unearned income, the first $85 of earned income, instead of the first $65, is not counted.

Income and SSI amounts are figured on a quarterly basis and monthly payments are arrived at by prorating quarterly figures.

Chart 39

EXAMPLES OF PAYMENT COMPUTATIONS

(USING BENEFIT LEVELS EFFECTIVE JULY 1976)

A. SINGLE PERSON GETTING SOCIAL SECURITY BENEFIT OF $108.00 ($324.00 a quarter)

BASIC QUARTERLY SSI	$503.40
COUNTABLE SOCIAL SECURITY	-264.00
QUARTERLY SSI AMOUNT	$239.40
MONTHLY SSI PAYMENT	$ 79.80
SOCIAL SECURITY	108.00
TOTAL MONTHLY INCOME	$187.80

B. SINGLE PERSON WITH EARNED INCOME OF $250 ($750 a quarter) NO RETIREMENT INCOME

QUARTERLY EARNINGS	$ 750
	-255
÷2	495
COUNTABLE	$247.50
BASIC QUARTERLY SSI	$503.40
COUNTABLE EARNINGS	-247.50
QUARTERLY SSI AMOUNT	$255.90
MONTHLY SSI PAYMENT	$ 85.30
MONTHLY EARNINGS	250.00
TOTAL MONTHLY INCOME	$335.30

Chart 39

EXAMPLES OF PAYMENT COMPUTATIONS (continued)

C. COUPLE WITH MONTHLY UNEARNED INCOME OF $120 ($360 a quarter) AND EARNED INCOME OF $180 ($540 a quarter)

UNEARNED INCOME	$360
	− 60
COUNTABLE UNEARNED INCOME	$300
EARNED INCOME	$540
	−195
	345
÷2	
	$172.50

BASIC QUARTERLY SSI	$755.40
COUNTABLE UNEARNED INCOME	−300.00
COUNTABLE EARNINGS	−172.50
QUARTERLY SSI AMOUNT	$282.90

MONTHLY SSI PAYMENT	$ 94.30
MONTHLY UNEARNED INCOME	120.00
MONTHLY EARNINGS	180.00
TOTAL MONTHLY INCOME	$394.30

STATE SUPPLEMENTATION

- MANDATORY STATE SUPPLEMENTATION: REQUIRES STATES TO MAINTAIN DECEMBER 1973 INCOME LEVELS FOR DECEMBER ASSISTANCE RECIPIENTS

- OPTIONAL STATE SUPPLEMENTATION: STATES MAY PROVIDE GENERAL SUPPLEMENTATION OF THE FEDERAL PAYMENTS

- A STATE THAT ELECTS FEDERALLY ADMINISTERED OPTIONAL STATE SUPPLEMENTATION MAY VARY ITS PAYMENTS

  1. TO INDIVIDUALS AND COUPLES
  2. BY CATEGORY (AGED, BLIND, DISABLED)
  3. FOR VARIOUS LIVING ARRANGEMENTS (LIVING ALONE, IN A BOARDING HOUSE, ETC. -- LIMIT OF 5 VARIATIONS)
  4. BY GEOGRAPHICAL AREA (LIMIT OF 3 VARIATIONS)

(FEDERALLY ADMINISTERED STATE SUPPLEMENTS VARY FROM $2 FOR AN INDIVIDUAL TO $1050 FOR A COUPLE)

Chart 40
State Supplementation

The Federal minimum income levels are higher than the levels of assistance that were paid in more than half the states; most recipients in these states are receiving increased benefits as a result of the higher Federal levels and the states do not have to supplement the Federal payments for these people. States which generally paid assistance levels higher than Federal levels to all recipients and those that because of special circumstances or special needs paid at levels higher than the Federal levels to some recipients are required to supplement the SSI payments to maintain their public assistance recipients' December 31, 1973, income levels. Any state which does not maintain its public assistance recipients' December 31, 1973, income level will not receive Federal matching funds for Medicaid. (Texas, because of a State constitutional prohibition, is excluded from this requirement.) Many states have also agreed not to limit supplementary payments to only those people who received state assistance in December 1973. These states are making supplementary payments to selected groups (according to category or living arrangement) or under certain circumstances to all SSI recipients as well as to aged, blind, and disabled people who would, except for the fact that their incomes are above the SSI income limits, be eligible for SSI. States which provide supplementary payments and agree to Federal administration of the payments have all administrative costs paid by the Federal Government.

If a state provides an optional supplement (i.e., a payment not required to maintain a December 1973 recipient's December 1973 income) it may vary its payment levels but must do so within certain limits: it may vary its payments by category of recipients (aged, blind, disabled) and for individuals and couples. Additionally, it may pay varying amounts for the differences in the costs of maintaining various living arrangements (such as living alone, in another's household, or in a boarding house) but for no more than five living arrangements, or for geographical differences in living costs (usually urban versus rural residence) but for no more than three geographical variations.

FEDERAL ROLE IN ADMINISTERING STATE SUPPLEMENTARY PAYMENTS

1. Determine eligibility
2. Determine proper payment amounts
3. Issue checks
4. Perform quality reviews
5. Advise states of amounts they must remit monthly
6. Absorb full administrative costs
7. Assume liability for program costs above states' CY 1972 level of program expenditures

Chart 41

Federal Role in Administering State Supplementary Payments

A state may elect to have SSA administer either mandatory or optional supplements or both. Generally, if the state chooses to have its optional supplement federally administered, it must also have the Federal Government administer its mandatory supplement unless the state is able to provide sufficient justification for exemption from this requirement.

If SSA administers a state's mandatory payments, SSA determines the amount each recipient entitled to a state mandatory payment may receive by comparing total current income, including SSI, against total income for December 1973, including state assistance. If this latter amount is higher, the individual is entitled to receive the difference. This method of determining the mandatory payment amount also is applicable in the case of state administered mandatory payment programs.

If the state elects to have SSA administer an optional supplementation program, SSA computes the benefits payable to a recipient eligible for an optional supplement according to the variations in payment levels the state has elected.

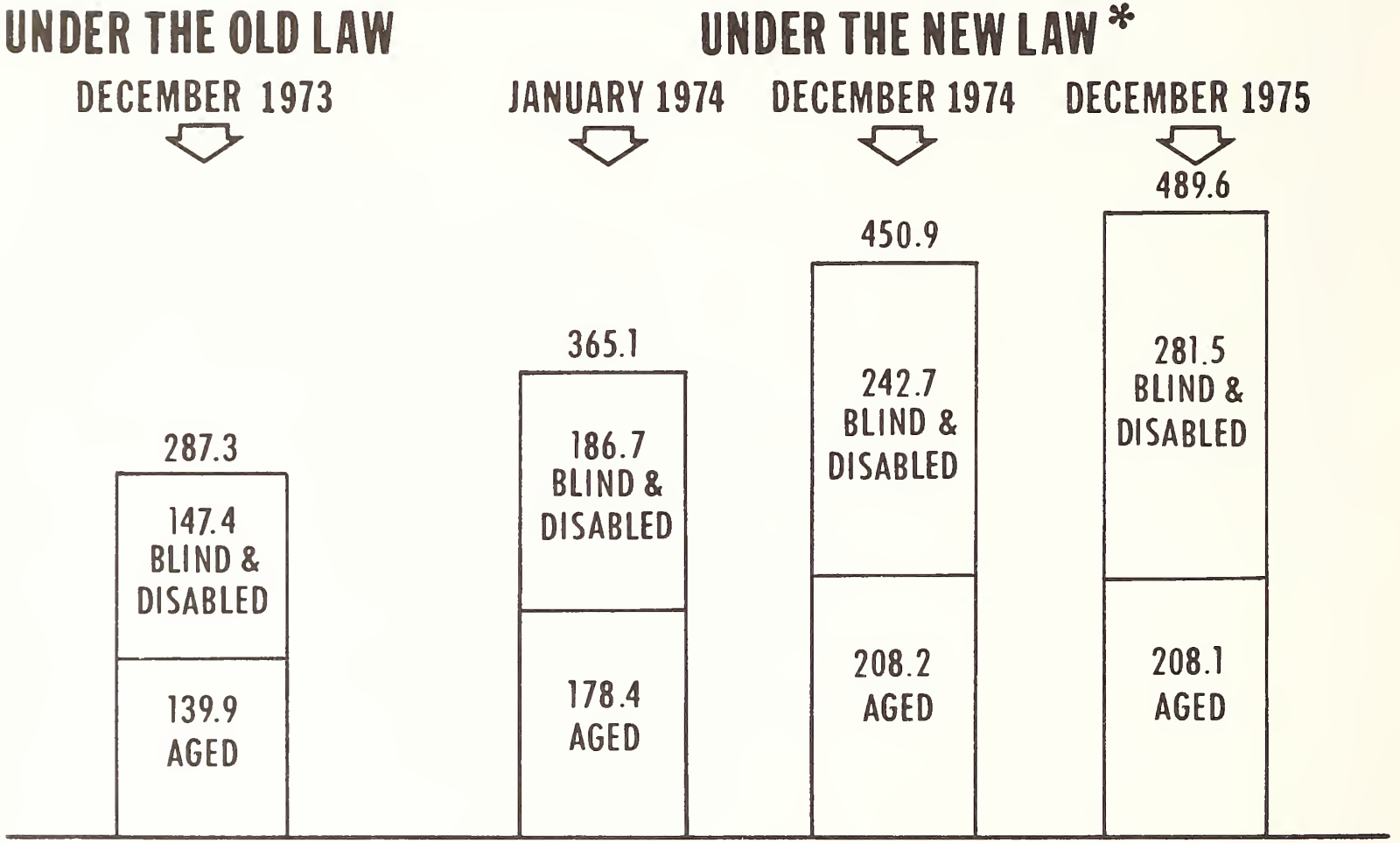
For both federally administered mandatory and optional payments, the state payment amount is combined with the Federal benefit amount in one check and the Federal Government assumes the full cost of administering the state supplementary payments. Additionally, federally administered state payments (as well as state administered mandatory payments) are included in the SSA quality review process.

Each month, the Federal Government advises states for which it administers supplementary payments of the amounts they must deposit with the Federal Government in order to meet their program payment obligations.

States are guaranteed that, if they provide payments which supplement the Federal SSI payments and which are administered by the Federal Government, it will cost them no more to do so than the amount of their total expenditures for cash public assistance payments to aged, blind, or disabled individuals during calendar year 1972. This guarantee applies only to the extent that the Federal payment and the state supplementary payments to recipients do not exceed the payment levels in effect under the public assistance programs in the state for January 1972 plus the bonus value of food stamps. The bonus value of food stamps is the value of the stamps reduced by the cost to the purchaser.

PROGRAM PAYMENTS

(IN MILLIONS OF DOLLARS)



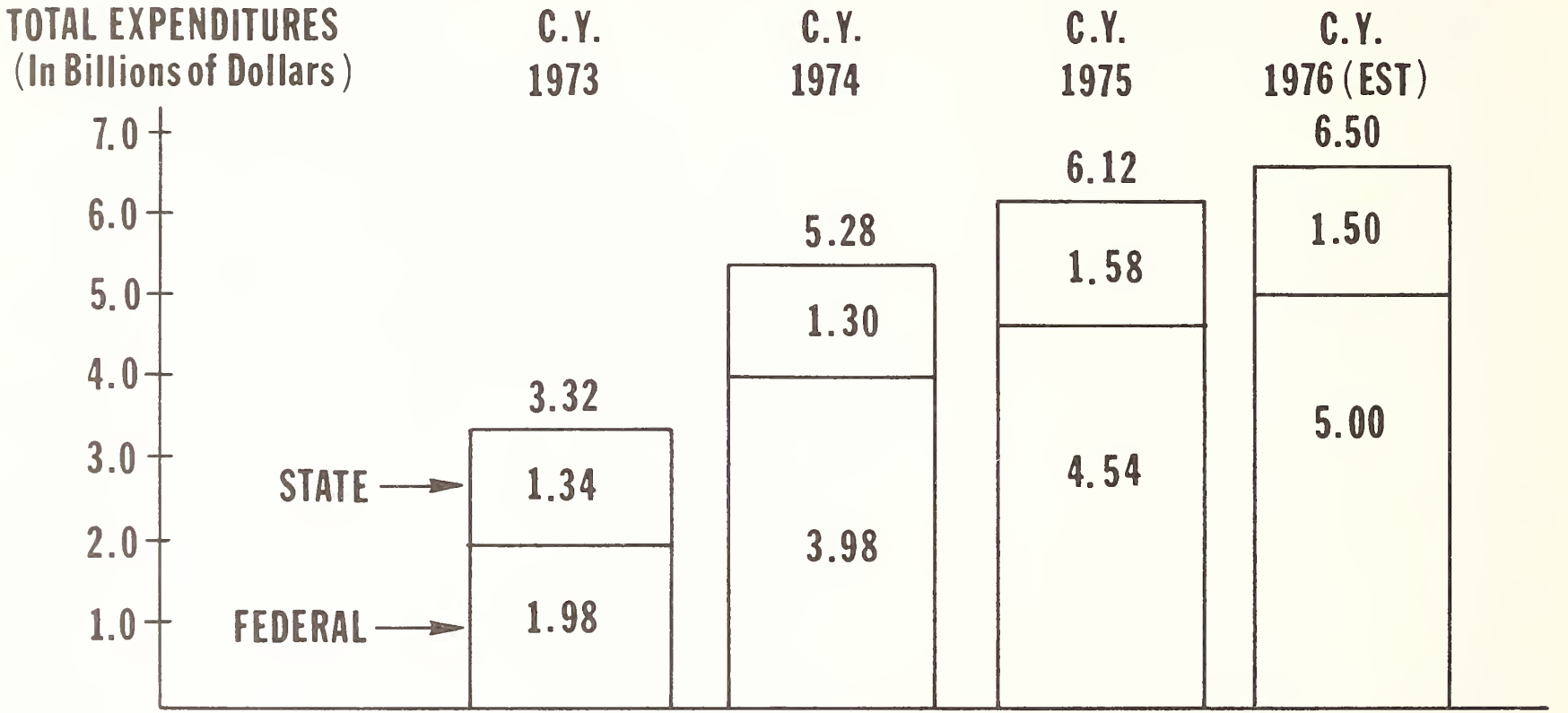
* Includes Federally administered state supplements.

Chart 42
Program Payments

SSI program payments included on the chart are Federal SSI benefits and federally administered state supplementary payments. State administered supplements, which averaged about $12 million a month in 1974, are not included.

A comparison of the payments for January 1974 and December 1974, under the SSI program, to the December 1973 payments, under the former state programs of adult assistance, shows that total program expenditures for January 1974, the first month of the SSI program, were $77.8 million greater than total expenditures for December 1973, the last month of the former programs. Program expenditures for December 1974 exceeded December 1973 payments by $163.6 million. For December 1975, the difference in program expenditures over December 1973 amounts rose to $202.3 million.

COMPARISON OF FEDERAL AND STATE CALENDAR YEAR EXPENDITURES UNDER THE FORMER ADULT ASSISTANCE PROGRAMS WITH EXPENDITURES UNDER THE SSI PROGRAM*



* DATA FOR THE SSI PROGRAM (BEGINNING WITH 1974) INCLUDE BOTH FEDERAL AND STATE ADMINISTERED STATE SUPPLEMENT AMOUNTS

Chart 43

Comparison of Federal and State Calendar Year Expenditures Under the Former Adult Assistance Programs with Expenditures Under the SSI Program

Total program expenditures for 1974 under the SSI program increased over 1973 expenditures for payments under the former state programs of adult assistance by $1.96 billion. State expenditures decreased by $40 million for the same period, while there was an overall increase in Federal expenditures of $2.0 billion.

For 1975, total program expenditures reached $6.12 billion. For 1975, the level of state spending exceeded its 1973 level by $240 million and Federal expenditures increased to $4.54 billion—more than double their 1973 level of $1.98 billion.

Estimates for 1976 indicate that total program expenditures for the year will reach $6.5 billion. For 1976, the level of state spending is expected to exceed its 1973 level by $160 million, whereas Federal expenditures will increase to $5 billion—more than 2 1/2 times their 1973 level of $1.98 billion.

FROM SSI APPLICATION TO CHECK

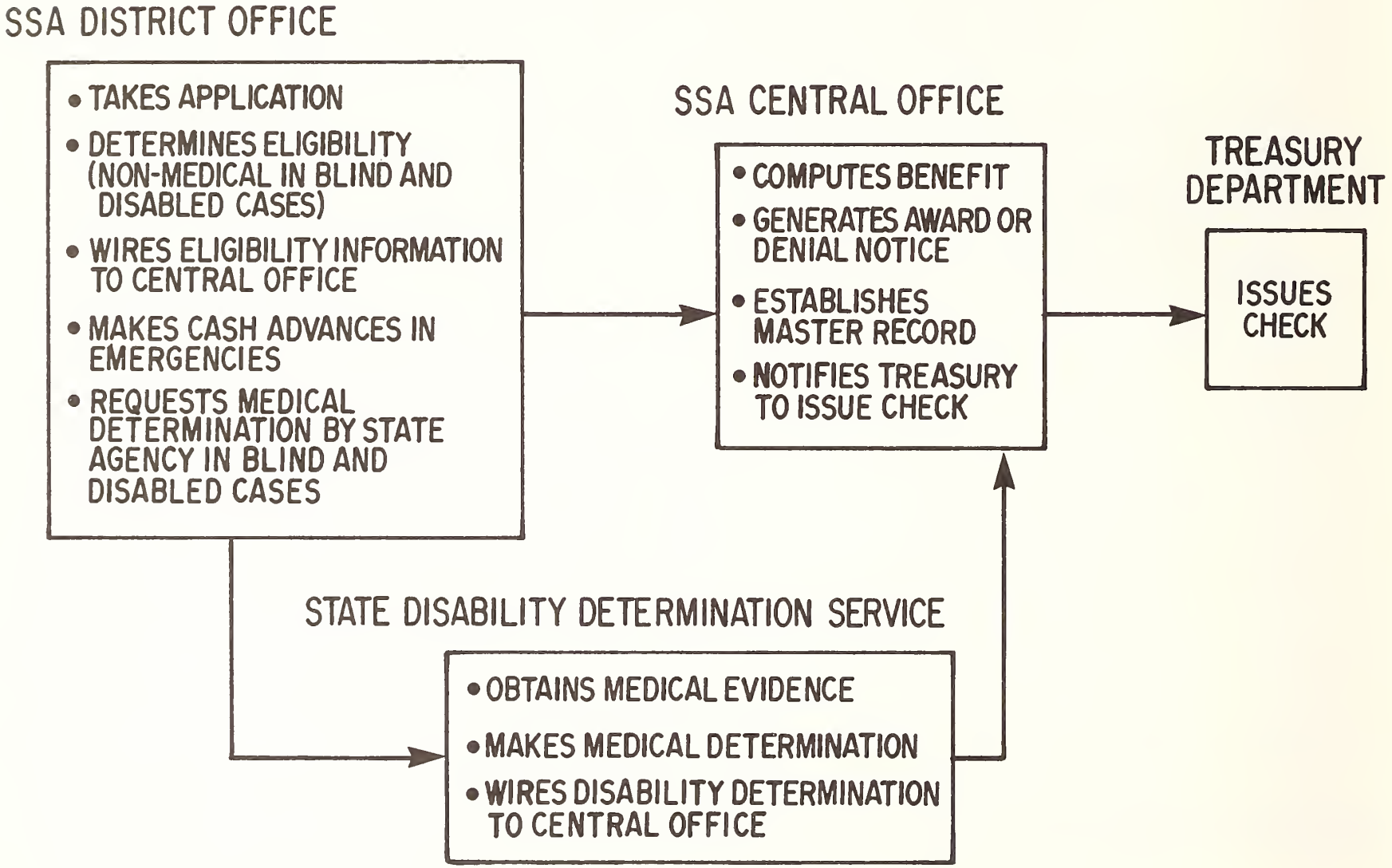


Chart 44
From SSI Application to Check

This chart outlines the major functions that are performed in carrying out the SSI program.

The district office (DO) takes applications from aged, blind, and disabled persons along with evidence as to identity, age, income, resources, and any other factors necessary to establish eligibility. The DO is responsible for making eligibility determinations in the aged cases; however, in the blind and disabled cases, they are only responsible for making determinations on nonmedical factors.

Payments may be made to a representative payee under circumstances comparable to those where representative payment is made under the social security insurance programs. A representative payee must be named, however, where the recipient is disabled and medically determined to be a drug addict or alcoholic.

If the DO receives information from the claimant of a change in status (e.g., increase or decrease in income, a change in living arrangements, ineligibility of one member of a couple), this information is wired to Central Office. In addition, the DO makes periodic redeterminations to assess whether the beneficiary is still eligible.

In certain cases, the DO's may make advance emergency payments. An advance payment of up to $100 against the initial payment may be made to an applicant faced with financial emergency when there is a strong likelihood that such person initially applying for payments will be found eligible. The advance is then deducted from future payments due the individual. The DO may make up to 3 months' payment to an individual applying for *disability* benefits (pending SA approval) when a prima facie case has been made that the individual will be found eligible. In cases where the applicant is later found to be not disabled, these payments are not considered overpayments and will not be recovered.

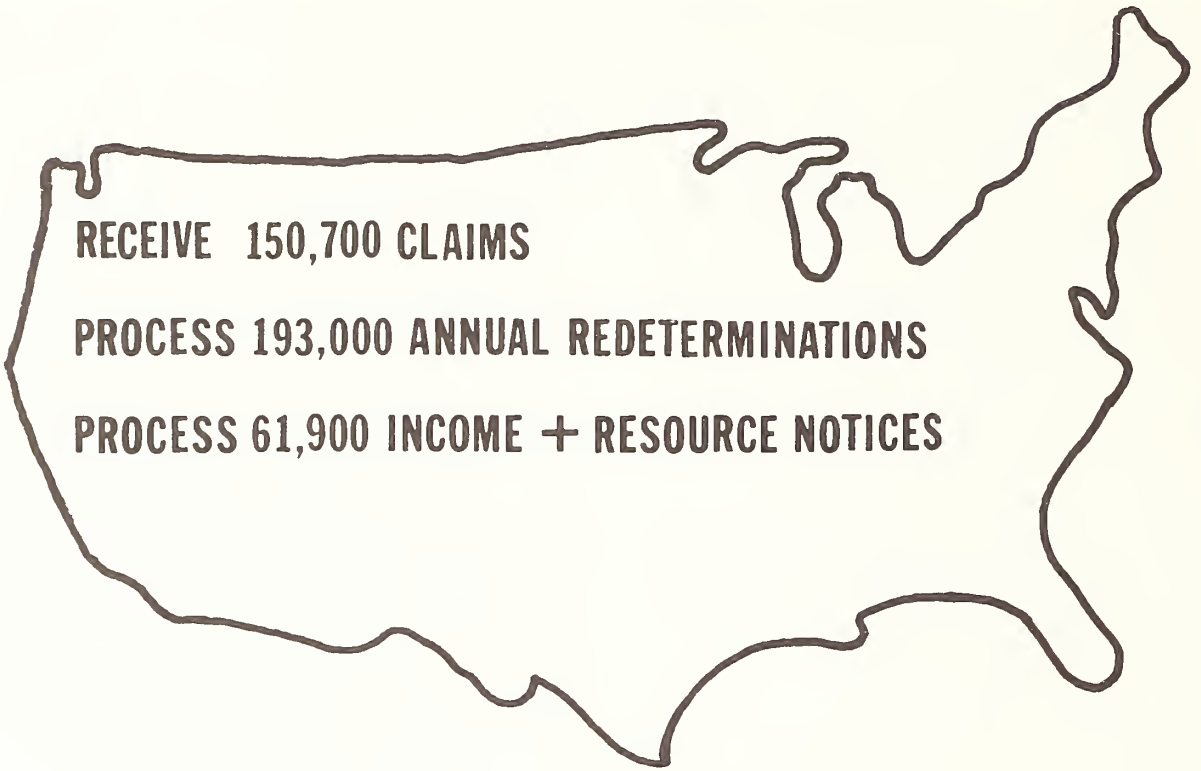
In addition to the nonmedical information collected by the DO, disabled and blind persons must have a formal medical determination of eligibility. This determination is made by a disability agency of the state after all medical evidence has been obtained, and is then forwarded through the telecommunication system to Central Office where it is matched up with the other data on the case.

After the DO's make their eligibility determinations and any medical determination by the SA, the eligibility data is wired to Central Office and is entered into the Supplemental Security Record (SSR). All DO's have access to these records through special telecommunication lines, but for 483 of the larger offices, a new high-speed electronic system called SSADARS—Social Security Administration Data Acquisition and Response System—has been installed. The DO's may also use the system to make inquiries about persons who have previously filed claims for SSI and/or social security insurance benefits.

In SSA Central Office, an SSI master record is established. All information in this master record is screened against existing social security master records. Computation of the monthly benefit amount is then made from this data. As a result of this computation, either an award notice or notice of ineligibility is sent to the SSI claimant. SSI checks are then issued by the Treasury Department from magnetic tapes furnished by SSA to Treasury Regional Disbursing Centers. The benefit amount is adjusted if information on a posteligibility event indicates a change in existing data. Central Office also verifies the eligibility of a person to receive an advance emergency payment.

In cases where an individual may be eligible for other benefits or for social services, the DO makes referrals to other public and voluntary agencies.

SSI WORKLOADS IN DISTRICT OFFICES EACH MONTH



WORKLOADS — MONTHLY AVERAGE, FISCAL YEAR 1975

Chart 45

SSI Workloads in District Offices

During fiscal year 1975, SSA was faced with continued heavy workloads because of the implementation of the SSI program.

District offices received a monthly average of 150,700 initial old age, blind, and disabled claims. Also, each month they completed an average of 193,000 SSI eligibility redeterminations. In addition to this, they processed an average of 61,900 income and resources notices, as well as a substantial number of other postadjudicative actions, such as claims reconsiderations, death notices, recovery of overpayments, nonreceipt of checks, and address changes.